

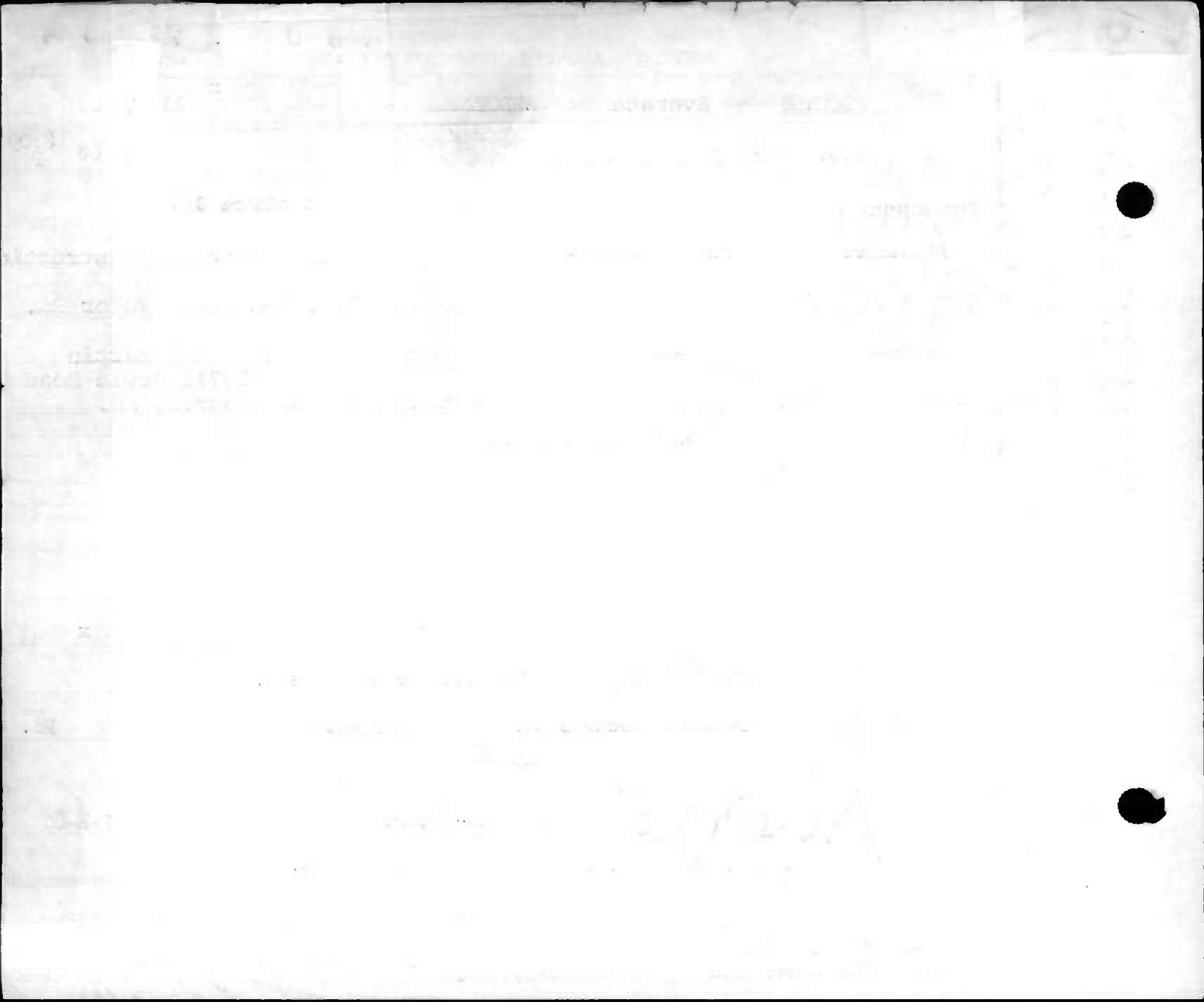
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		0 27 / 84	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE KNOWN OF DEATH	
FIRST MIDDLE LAST DONALD Everett ABBOTT		ESTIMATED MONTH DAY YEAR HOUR <input checked="" type="checkbox"/> 11 7 1980 M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)
male	white	MONTH DAY YEAR Oct 29 1918	LAST BIRTHDAY 62 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
Tennessee		U S A	Baltimore City
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Baltimore		University Hospital	Pile Driver
13a. STATE		13b. COUNTY	13c. CITY OR TOWN
Maryland		Calvert	Riva
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	
James Abbott		Nova Lee Martin	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
Yes WWII			
17. INFORMANT		ADDRESS	
Nova Lee Abbott		14711 Bowie Road Laurel, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Abdominal injuries			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.			
(b) DUE TO, OR AS A CONSEQUENCE OF			
(c) DUE TO, OR AS A CONSEQUENCE OF			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY?			
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR MINUTE MONTH DAY YEAR 12:01 AM 11-5-1980	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		Subject struck by beam.	
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
Potomac Electric Co.		Morgantown Md.	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .			
ACTUAL SIGNATURE		TITLE (SPECIFY)	
Ann M. Dixon, M.D.		Assistant MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT)		DATE SIGNED	
		11-8-80	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
Burial		12 Nov 1980	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN	
Cedar Hill Cemetery		Suitland PG Md	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR	
Robert E. Wilhelm		NOV 13 1980	
Funeral Home Inc		25b. REGISTRAR'S SIGNATURE	
Suitland, Md.		[Signature]	





27785

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>WILLIAMS, Russell ABBOTT</b>		2a. DATE OF DEATH MONTH <b>11</b> /DAY <b>13</b> /YEAR <b>80</b>		2b. HOUR <b>2:30</b> P.M.	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>10</b> /DAY <b>5</b> /YEAR <b>1913</b>	
6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> /DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> /MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore County</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b>		MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>JOHNS HOPKINS HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Carpenter</b>	
12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Westminster</b>	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>57 John St.</b>			
14. FATHER'S NAME FIRST <b>William</b> MIDDLE <b>Carl</b> LAST <b>Abbott</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Florence</b> MIDDLE <b></b> LAST <b>Myers</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>217-16-1183</b>		17. INFORMANT ADDRESS <b>Westminster, Md.</b> <b>Helen Irene Abbott 57 John St. 21157</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY <b>Radio Respiratory Arrest</b> IMMEDIATE CAUSE (a) <b>1629</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <b>Brain Metastases</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cancer of Lung</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>11/13</b> , 19 <b>80</b> , to <b>11/13</b> 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>11/13</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>DRUCKER</b>		DEGREE		22c. DATE SIGNED <b>11/13/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DRUCKER</b>		22e. ADDRESS <b>JHW</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-17-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westminster Cemetery</b>	
23d. LOCATION CITY OR TOWN <b>Westminster</b>		COUNTY <b>Carroll</b>		STATE <b>Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Thomas D. Fletcher &amp; Son F.H.</b>		25. DATE REC'D. BY REGISTRAR <b>NOV 19 1980</b>		26. REGISTRAR'S SIGNATURE <b>Robert K. Crosby</b>	

PLPDSPIE 110

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

REG. NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. BASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2b. DATE KNOWN OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
Angela		M.	Adams	11		1	1980	M				
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD		MONTH	DAY	YEAR	2d. HOUR
Female	Black	11 25 56		23 YRS.	MONTHS	DAYS	11 1 1980		11:08 a		M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
MD		USA				Baltimore City, MD						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Baltimore City		1322 E. Fayette Street										
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS				
MD				Baltimore				1322 E. Fayette St.				
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME										
FIRST MIDDLE LAST		FIRST MIDDLE LAST										
Willie		Adams		Mattie E. Cummings								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS						
No		215-64-9735		Mattie E. Adams		1322 E. Fayette St.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 3480 IMMEDIATE CAUSE (a) Colloid cyst of third ventricle DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE		TITLE (SPECIFY)				MEDICAL EXAMINER		DATE SIGNED				
Thomas D. Smith, M.D.		Deputy Chief						11/1/80				
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS				111 Penn St. Balto., MD.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE						
Burial		11/6/80		Cedar Hill Cem.		Baltimore Co. MD						
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
Wm. C. March F/H		1101 E. North Ave.		NOV 5 1980		[Signature]						

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				80 27787	
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH	
FIRST MIDDLE LAST Evelyn Crady Adams				MONTH DAY YEAR Nov 8, 1980	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 22 1884	
6. AGE (IN YEARS LAST BIRTHDAY) 96 YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ky.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		10. CITY OR TOWN OF DEATH Baltimore	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Long Green N.H.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Social Worker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md		13b. COUNTY		13c. CITY OR TOWN Baltimore	
14. FATHER'S NAME FIRST MIDDLE LAST William Henry Crady		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cora Brown		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	
16b. SOCIAL SECURITY NO. 402-62-1085		17. INFORMANT Evelyn Crady Handy		ADDRESS 4300 N. Charles St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4392 A-S Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis, severe DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yr. 5 yr.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (the deceased) attended the deceased from above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Norman R. Freeman MD	
22c. DATE SIGNED Nov 8, 1980		22d. PHYSICIAN'S NAME (TYPE OR PRINT) N. R. FREEMAN M.D.		22e. ADDRESS 11 N. 29th St, Baltimore Md	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 11/8/80		23c. NAME OF CEMETERY OR CREMATORY	
23d. LOCATION CITY OR TOWN COUNTY STATE		24. FUNERAL DIRECTOR NAME Anatomy Board		25a. DATE REC'D. BY REGISTRAR NOV 17 1980	
25b. REGISTRAR'S SIGNATURE Kristy Kelly		25c. REGISTRAR'S NAME Balto., Md.		25d. REGISTRAR'S ADDRESS	



Amesbury Board  
Sept. 1895

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		ADAMS HARRY / 1 / 8 8 07 30 25				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Harry Irvin Adams					2a. DATE OF DEATH MONTH DAY YEAR November 28, 1980			2b. HOUR 5:43pm	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 30, 1925		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Johns Hopkins Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic		12b. KIND OF BUSINESS OR INDUSTRY Liskey, Inc.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Baltimore Rosedale					13d. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7933 33rd St.		
14. FATHER'S NAME FIRST MIDDLE LAST Charles E. Adams					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Kornauer				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-22-6429		17. INFORMANT ADDRESS Dorothea P. Adams, 7933 33rd St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular arrhythmia</u> <u>3960</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>aortic &amp; mitral valvular heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>rheumatic fever</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u> <u>since age 20</u> <u>age 10 &amp; 40</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION <u>11/28/80</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>aortic regurg/ mitral stenosis &amp; regurgitation</u>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from <u>11/24</u> , 19 <u>80</u> , to <u>11/28</u> , 19 <u>80</u> , that (we) lost saw the deceased alive on <u>11/28</u> , 19 <u>80</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>L. M. Keilly</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>11/28/80</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>L. M. Keilly</u>					22e. ADDRESS <u>Johns Hopkins Hospital</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 2, 1980		23c. NAME OF CEMETERY OR CREMATORY Parkwood		23d. LOCATION CITY OR TOWN COUNTY STATE Parkville, Baltimore, Md.			
24. FUNERAL DIRECTOR NAME ADDRESS ROBERT C. ALTENBURG FUNERAL HOME, INC. 6009 Harford Rd., Balto., Md. 21214					25a. DATE REC'D. BY REGISTRAR DEC 2 1980		25b. REGISTRAR'S SIGNATURE <u>Robert C. Altensburg</u>		

1948-1949 29208  
1949-1950 29209



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DDMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				80 27789	
1. FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>James Bradford Adams</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>11 29 80</b> 2b. HOUR <b>3:40 AM</b>	
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 10 13</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST AGNES HOSPITAL</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
13a. STATE <b>md</b>		13b. COUNTY <b>Balto</b>		13c. CITY OR TOWN <b>Catonsville</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Howard L. Adams</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emma Palmer</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Supervisor</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>212032446</b>		17. INFORMANT ADDRESS <b>Mrs. Margaret A. Adams Same as #13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <b>M.I. Myocardial Infarction</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>11 29 80</b> P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>11/29</b> 19 <b>80</b> to <b>11/29</b> 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>11/29</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>J. L. Lewis</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>11/29/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOFFRE LEWIS</b>		22e. ADDRESS <b>ST AGNES</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/2/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Mem.</b>	
24. FUNERAL DIRECTOR NAME <b>MacNabb Funeral Home</b>		ADDRESS <b>Catonsville, Md.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Lutherville Balt. Md.</b>	
25a. DATE REC'D. BY REGISTRAR <b>DEC 2 1980</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

MEDICAL CERTIFICATION



BALTIMORE CITY

ET AGNES HOSPITAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0	2 7 7 9 0
1. FOR STATE REGISTRAR		CERTIFICATE OF DEATH				REG. NO.				10:15A	
1. DECEASED NAME (TYPE OR PRINT)		FIRST ROBERT		MIDDLE ADAMS		LAST ADAMS		2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 4, 1980		2b. HOUR 10:15 am	
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 11/20/32		6. AGE (IN YEARS LAST BIRTHDAY) 47 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD.					
10. CITY OR TOWN OF DEATH BALTO		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CHURCH HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Auto		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY BALTO		13c. CITY OR TOWN DUNDALK		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6710 BESSEMER AVE			
14. FATHER'S NAME FIRST MIDDLE LAST JOHN ADAMS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BEULA HOLBROOKS									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNK		16b. SOCIAL SECURITY NO. 452 40 8823		17. INFORMANT ADDRESS ESTHER ADAMS ABOVE							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF <u>RESPIRATORY FAILURE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Respiratory failure</u> (c) <u>Hepatic failure due to alcoholic hepatitis</u> DUE TO, OR AS A CONSEQUENCE OF <u>Hepatic failure due to Alcoholic hepatitis</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Staphylococcal septicemia</u> <u>STAPHYLOCOCCAL SEPTICEMIA</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) YANXX		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>11-4-8</u> , 19 <u>80</u> , to <u>11-14</u> , 19 <u>80</u> , that (I) (we) lost the deceased alive on <u>11-4-8</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE F. Khwaja		DEGREE M.B.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11-14-80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) TAHOORA KHWAJA, M.D.		22e. ADDRESS 200 N. BROADWAY BALTIMORE MD 21231									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 11/7/80		23c. NAME OF CEMETERY OR CREMATORY HOLLY HILL		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD					
24. FUNERAL DIRECTOR NAME J.E. CONNELLY		ADDRESS 300 MALE		25a. NOV 12 1980							

*[Faint, illegible handwriting throughout the page]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. STATE REGISTRAR <b>GEORGE GEORGE BAILEY AIRE</b>					80 27791 CERTIFICATE OF DEATH				
1. DECEASED NAME (TYPE OR PRINT) <b>GEORGE JAMES AIRE</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>11-23-80</b> 2b. HOUR <b>8:00A</b>				
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>APRIL 24, 1906</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>BALTIMORE, MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY, MD.</b>			
10. CITY OR TOWN OF DEATH <b>BALTIMORE, MD.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BALTIMORE CITY HOSPITALS</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>SEABOARD STEEL</b>	
13a. STATE <b>MD.</b>		13b. COUNTY <b>---</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>505 TOLNA ST. 21224.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JAMES AIRE</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>FRANCES GUMMER</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>217-16-1202</b>		17. INFORMANT <b>VICTORIA V. AIRE</b>		ADDRESS <b>505 TOLNA ST. BALTO., 21224, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b> <b>4960</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>END STAGE COPD.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>SMOKING.</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>11/20</b> 19 <b>80</b> , to <b>11/23</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>11/23</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I/we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>A. JAIN</b>				DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>11/23</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>A. JAIN</b>				22e. ADDRESS <b>BALTO. CITY HOSP.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>11-26-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. STANISLAUS CEM.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>5615 BOSTON AVE. BALTO., MD.</b>			
24. FUNERAL DIRECTOR NAME <b>Charles S. Jailer &amp; Sons, Inc.</b> ADDRESS <b>6224 EASTERN AVE. BALTO., 21224, MD.</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 25 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Robert K. Bailey</b>			

BP

( 200 )

1945

UNITED STATES

DEPARTMENT OF JUSTICE

ANTITRUST DIVISION

WASHINGTON, D.C.

IN RE: THE MERGERS OF

AMERICAN AIRLINES

ET AL.

AND

UNITED STATES AIRLINES

ET AL.

AMERICAN AIRLINES

UNITED STATES AIRLINES

ET AL.

(10-10-45)

4504 BP  
 DHMH-16 30M 2/80  
 (VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										80 27792	
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
FIRST MIDDLE LAST BARNEY P ALBERT				MONTH DAY YEAR NOV 25 80				6:00 P.M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
MALE		Caucasian		MONTH DAY YEAR 5 25 93		87 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Baltimore		U.S.A.				Baltimore City MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		South Baltimore Gen. Hospital				Mechanist					
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Md.				Essex		Essex		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1 Eastern Blvd. Riverview Nurs. Center	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST Leonard P. Albert				FIRST MIDDLE LAST Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS					
Unknown		215-05-5467		JIM MERRITT (Grandson)		416 Nollmeyer Rd. Baltimore, Md 21220					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u>											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		HOUR A.M. MONTH DAY YEAR P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION							
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct. 26, 1980</u> , to <u>Nov. 6, 1980</u> , that (I) (we) last saw the deceased alive on <u>Nov. 6, 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
Susan Voss, MD				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				11/6/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
SUSAN VOSS, MD				South Baltimore Gen. Hosp. 3001 S. Hanover St. Baltimore, Md. 21230							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION					
BURIAL		11/10/80		OAK LAWN		BALTO. COUNTY MD.					
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
J. G. CONNELLY				300 MACE				NOV 12 1980			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>JAMES</b>		FIRST <b>ALEXANDER</b>		LAST		2a. DATE OF DEATH MONTH DAY YEAR <b>11/18/80</b>		2b. HOUR <b>8:40 AM</b>	
3. SEX <b>MALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8 31 1896</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNION MEMORIAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Usher</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Theater</b>	
13a. STATE <b>MD</b>		13b. COUNTY		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1639 Division St. 21217</b>	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anne</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>204071908</b>		17. INFORMANT ADDRESS <b>MEDICAL RECORD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>4330</b> IMMEDIATE CAUSE (a) <b>BASILAR ARTERY THROMBOSIS</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>upper GI bleed</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>11/13</b> , 19 <b>80</b> , to <b>Nov 18</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>Nov 18</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Julian T. Simmons</b>				DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/18/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JULIAN T. SIMMONS</b>				22e. ADDRESS <b>UNION MEMORIAL HOSP</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>11/21/80</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b>				ADDRESS <b>Balto., Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 28 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Richard M. Brady</b>	



Theater

Heber

W. H. H. H. H.

W. H. H. H. H.

from

W. H. H. H. H.

W. H. H. H. H.

for

NOTICE



RECEIVED

RECEIVED

NOV 28 1980

PAID TO: INC.

PAID TO: INC.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 27794

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>SUSIE</b>			FIRST MIDDLE LAST <b>ALEXANDER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOV. 11 19 80</b>			2b. HOUR <b>3 55</b> M		
3 SEX <b>FEMALE</b>			4 RACE <b>BLACK</b>			5. DATE OF BIRTH DAY MONTH YEAR <b>3 4 06</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.		
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNIVERSITY HOSPITAL</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOMEMAKER</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>		
13a. STATE <b>MD</b>						13b. COUNTY <b>BALTO CITY</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>REDOCK</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ANNIE PORTER</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>						16b. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>DELORIS CLARK</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>5739 IMMEDIATE CAUSE (a) LIVER DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF: (b) <b>CHRONIC RENAL FAILURE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>GASTROINTESTINAL BLEED</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION <b>N/A</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>N/A</b>			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>N/A</b>			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>N/A</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>N/A</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> <b>N/A</b>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>N/A</b>			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>N/A</b>					
22a. I certify that (I) (this hospital) attended the deceased from <b>NOV 22</b> , 19 <b>80</b> , to <b>NOV 19</b> , 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>NOV 19</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I am (I) did not (did not) view the body after death.											
22b. SIGNATURE <b>Blaise D. Behrman</b>						DEGREE <b>MD</b>			22c. DATE SIGNED <b>11/19/80</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BLAISE D. BEHRMAN, M.D.</b>						22e. ADDRESS <b>UNIVERSITY HOSPITAL</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>11/24/80</b>			23c. NAME OF CEMETERY OR CREMATORY <b>BALTO NATIONAL CM</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>		
24. FUNERAL DIRECTOR <b>MARSHALL W JONES JR/4101</b>						25a. DATE REC'D. BY REGISTRAR <b>NOV 21 1980</b>			25b. REGISTRAR'S SIGNATURE <b>Patricia Hardy</b>		



Handwritten signature or initials.

1951

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 7 7 9 5

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>EDWARD ALLEN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 2, 1980</b>		2b. HOUR <b>10:00A.</b>
3. SEX <b>Male</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>11 24 38</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>41</b>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. <b>BALTIMORE CITY OR COUNTY OF DEATH</b> <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Balto.</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Church Home &amp; Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b>		13b. CITY OR TOWN <b>Balto.</b>	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>3808 Derby Manor Drive</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Benjamin Allen</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mildred Thomas</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	17. INFORMANT <b>Pauline Brown</b>		ADDRESS <b>3808 Derby Manor Dr.</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SEIZURE, CARDIORESPIRATORY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>HYPOGLYCEMIA, PNEUMONIA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>DIABETES</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
---	--	---

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>HISTORY OF DRUG ADDICTION</b>			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>NOVEMBER 2, 19 80</b> , to <b>NOVEMBER 2, 19 80</b> , that (I) (we) last saw the deceased alive on <b>NOVEMBER 2, 19 80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (I) (did not) view the body after death.)			
22b. SIGNATURE <b>Edward J. Britt</b> DEGREE		22c. PHYSICIAN'S NAME (TYPE OR PRINT) <b>EDWARD J. BRITT</b>	
22d. ADDRESS <b>CHURCH HOSPITAL CORPORATION, 100 N. BROADWAY, BALTIMORE, MD. 21231</b>		22e. DATE REC'D. BY REGISTRAR <b>NOV 5 1980</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>11/8/80</b>	23c. NAME OF CEMETERY OR CREMATORY <b>King Mem. Pk.</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co., Md.</b>
24. FUNERAL DIRECTOR NAME <b>Wm C March F/H</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 5 1980</b>	
ADDRESS <b>1101 E. North Ave.</b>		25b. REGISTRAR'S SIGNATURE <b>Robert A. Brady</b>	

RECEIVED  
1722 5112 75

(14)

RECEIVED 1722 5112 75

4/1/14

W. J. ...

1722 5112 75

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 80 27796  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
ROBERT ALLEN					11	21	80		8:55P M
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS		
MALE	BLACK	MONTH DAY YEAR 11 1 91		89 YRS.	MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
TENNESSEE	U.S.A.			BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
BALTIMORE	VETERANS ADMINISTRATION MEDICAL CENTER		RETIRED		LUMBER				
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS				
MARYLAND			BALTIMORE	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	7122 Walnut Avenue				
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)					
JOHN HENRY ALLEN		UNK		YES WW 2 414 12 0963 VAMC Clinical Records Balto., Md. 21218					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		18b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> 1551 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cochexia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Metastatic Adenocarcinoma</u>		414 12 0963		VAMC Clinical Records		Balto., Md. 21218			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)				Penal Failure					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
10/25/80	Exploratory Laparotomy	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
	8:56 P.M. 11/21/80								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>OCTOBER 6, 1980</u> , to <u>NOVEMBER 21, 1980</u> , that (I) (we) last saw the deceased alive on <u>NOVEMBER 21, 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		22c. DATE SIGNED					
ISA S. KANAWATI		MD		11/22/80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
ISA S. KANAWATI		3900 Loch Raven Blvd. Balto., Md. 21218							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
BURIAL	11/26/80	ST. THOMAS CEMETERY		RANDALLSTOWN (BALTO.) MD.					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
LEWIS T. GWYNN		4517 PARK HEIGHTS AVENUE		NOV 25 1980					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The medical examiner must be notified of once.



TO: [illegible]  
FROM: [illegible]  
SUBJECT: [illegible]  
[illegible text follows]

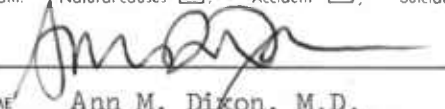

[illegible text follows]

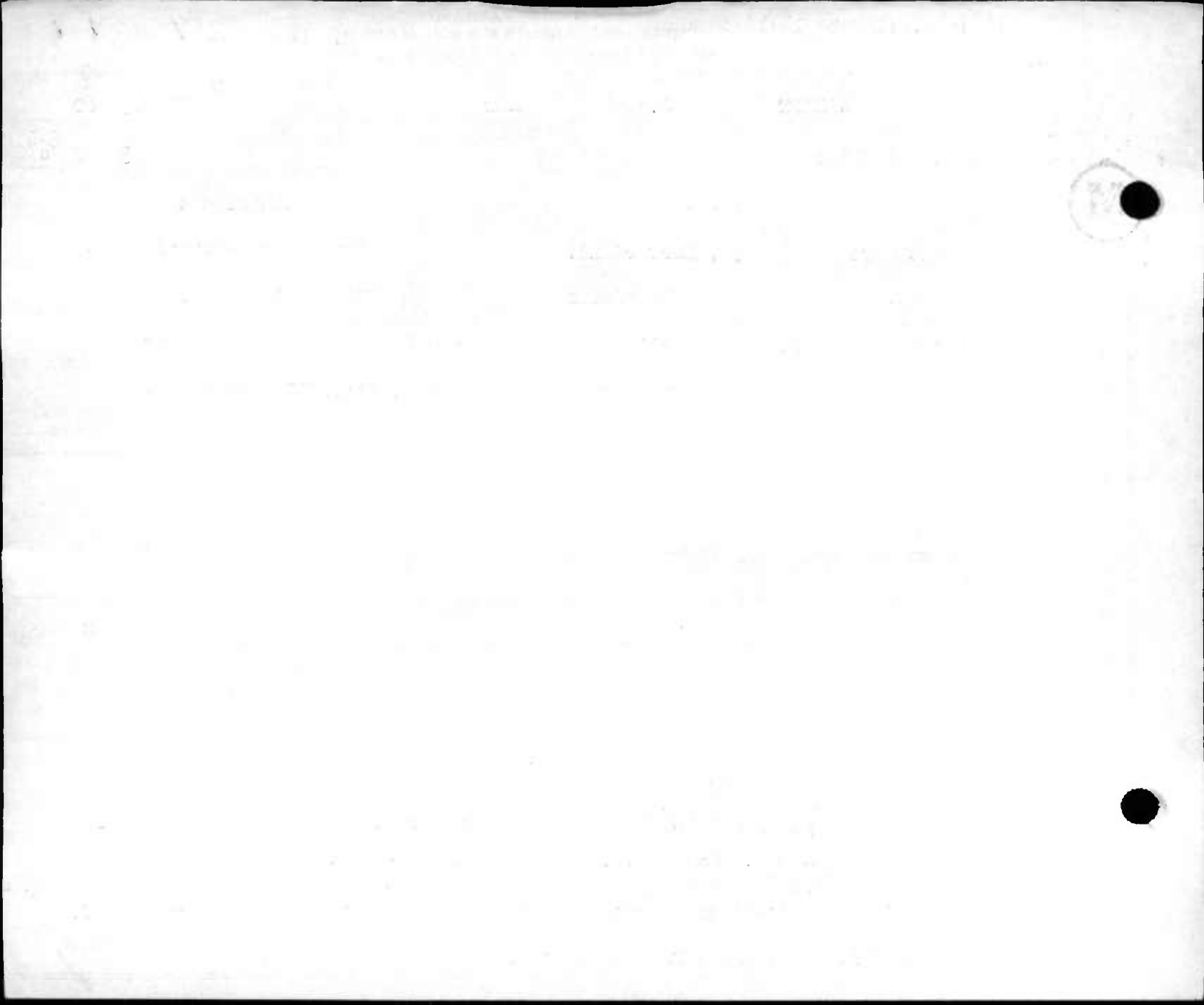
[illegible text follows]



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS INEVITABLE. PLEASE EXCLUDE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 4 FOR OUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										REG. NO. 27797	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT) <b>ALBERT Joseph ALT</b>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>11 13 80</b>	
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>3-26-60</b>		6. AGE (IN YEARS) <b>20</b>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2b. HOUR <b>6:41</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>6507 Harford Rd.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Layout Man--Printing Co.</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Md.</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>6210 Hilltop Ave.</b>			
14. FATHER'S NAME <b>Albert F. Alt</b>				15. MOTHER'S MAIDEN NAME <b>Dorothy Bond</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>213-48-0447</b>		17. INFORMANT <b>Albert F. Alt</b>		ADDRESS <b>6507 Harford Rd.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>3049</b> IMMEDIATE CAUSE (a) <b>Narcotism complicated by bronchopneumonia</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 				TITLE (SPECIFY) <b>Assistant</b>				DATE SIGNED <b>11-13-80</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>				ADDRESS <b>111 Penn St.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>11-17-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley</b>		23d. LOCATION CITY OR TOWN <b>Timonium</b>		COUNTY <b>Balto</b> STATE <b>Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Leonard J. Ruck, Inc.</b>				ADDRESS <b>5305 Harford Rd.</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 14 1980</b>		25b. REGISTRAR'S SIGNATURE 	



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 7 7 9 8

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>EARLE S. Anderson</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Nov. 17 1980</b>			2b. HOUR <b>2:15 A</b>				
3. SEX <b>MALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 19 1894</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City MD</b>				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Belair Chalmers</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Produce</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>FRUIT</b>		
13a. STATE <b>MD</b>		13b. COUNTY <b>DALTO</b>		13c. CITY OR TOWN <b>DALTO</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1417 Lombard ST</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>WARFIELD Anderson</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>SALLY</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>219-32-2214</b>		17. INFORMANT <b>Family</b>		ADDRESS <b>Records</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Renal Failure</b> <b>3319</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Renal CVA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cerebral Atrophy</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from <b>11-11</b> 19 <b>80</b> , to <b>11-11</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>11-13</b> 19 <b>80</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Howard H. Bond M.D.</b>						DEGREE <b>MD</b>		22c. DATE SIGNED <b>11/17/80</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Howard H. Bond M.D.</b>						22e. ADDRESS <b>9618 Belair Rd</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>11-19-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LEADER HILL</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Green Borne - A. A. Co. MD</b>			
24. FUNERAL DIRECTOR NAME <b>EVANS FUNERAL Chapel</b>						ADDRESS <b>8800 Harford Rd</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 20 1980</b>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



*[Faint, mostly illegible handwriting on lined paper, likely a letter or report.]*

NOV 21 1900

**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

8 0 2 7 7 9 9

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3. DATE OF BIRTH		4. AGE (IN YEARS)		5. IF UNDER 1 YR.	
Ollie Lavoid Anderson		6 - 22 - 40		40 YRS.		IF UNDER 24 HRS.	
1. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)	
Male		Black		6 - 22 - 40		40 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH	
Md.		U.S.A.		WIDOWED		Baltimore City, MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		Johns Hopkins Hospital		Mechanic		Box Co.	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Md.		Balto.		YES		NO	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.	
John Anderson		Carrie Lanier		Yes		After 1955	
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
Mrs. Carrie Anderson		Gunshot Wounds of Abdomen		19c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		20. AUTOPSY?	
1221 N. Bond St.		9654		Subject shot during altercation		YES	
1221 N. Bond St., Baltimore Md.		house		21a. INJURY OCCURRED		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
21c. HOW INJURY OCCURRED		21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION	
Subject shot during altercation		While at work		house		1221 N. Bond St., Baltimore Md.	
22a. I certify that I took charge of the remains described above, held on		22b. I certify that I took charge of the remains described above, held on		22c. I certify that I took charge of the remains described above, held on		22d. I certify that I took charge of the remains described above, held on	
death resulted from:		death resulted from:		death resulted from:		death resulted from:	
Natural causes		Natural causes		Natural causes		Natural causes	
Accident		Accident		Accident		Accident	
Suicide		Suicide		Suicide		Suicide	
Homicide		Homicide		Homicide		Homicide	
Undetermined manner		Undetermined manner		Undetermined manner		Undetermined manner	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		11-8-80		Baltimore Cemetery		Baltimore, Md.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE	
Randolph J. Collick		NOV 10 1980		R. J. Collick		R. J. Collick	
26. ADDRESS		26b. ADDRESS		26c. ADDRESS		26d. ADDRESS	
111 Penn Street		111 Penn Street		111 Penn Street		111 Penn Street	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

*[Faint, illegible text from bleed-through]*

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, FULFILL THE REQUIREMENTS OF THE "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. DATE OF DEATH			2c. DATE OF DEATH			2d. DATE OF DEATH			2e. DATE OF DEATH		
Maxin			Andrew			11 30 80			11 30 80			11 30 80			11 30 80		
3. SEX male			4. RACE black			5. DATE OF BIRTH 10 23 58			6. AGE (IN YEARS) 22 YRS.			IF UNDER 1 YR. MONTHS DAYS HOURS MIN.			7c. DATE PRONOUNCED DEAD 11 30 80		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Trinidad			7b. CITIZEN OF WHAT COUNTRY? Port of Spain			8. MARRIED WIDOWED			NEVER MARRIED			9. BALTIMORE CITY OR COUNTY OF DEATH BaltimoreCity			MD.		
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Social Security Administration			12b. KIND OF BUSINESS OR INDUSTRY								
13a. STATE Md.			13b. COUNTY			13c. CITY OR TOWN Balto.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS Greenspring Ave.					
14. FATHER'S NAME FIRST MIDDLE LAST Maxmilian Andrews			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Loretta Alexande			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no			16b. SOCIAL SECURITY NO. 219-76-2947			17. INFORMANT Mrs. Loretta Andrews 5241 St. Charles Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Stab wound of chest</b> 9660 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1:15xx 11/30 80			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject stabbed											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street			21f. LOCATION STREET CITY OR TOWN COUNTY STATE 4506 Park Heights Avenue, Baltimore, MD											
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE 			TITLE (SPECIFY) Assistant			MEDICAL EXAMINER			DATE SIGNED 11/30/80								
EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.			ADDRESS 111 Penn Street, Balto. MD 21201														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/3/80			23c. NAME OF CEMETERY OR CREMATORY King Memorial Pk.			23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md.								
24. FUNERAL DIRECTOR NAME Leroy O. Dyett			ADDRESS 4600 Liberty Heights Ave.			25a. DATE REC'D. BY REGISTRAR DEC 3 1980			25b. REGISTRAR'S SIGNATURE 								

0000



*Handwritten signature or mark.*

DEC 2 1900



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 2 7 8 0 1	
FOR 1. STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) MICHAEL T. ANDRIOTIS				2a. DATE OF DEATH MONTH DAY YEAR 11/27/80	
3. SEX male		4. RACE GREEK		5. DATE OF BIRTH MONTH DAY YEAR 9 5 89	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GREECE		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS. MONTHS DAYS HOURS MIN. IF UNDER 1 YEAR IF UNDER 24 HRS.	
10. CITY OR TOWN OF DEATH Baltimore				9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD.	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED	
13a. STATE Maryland				13b. COUNTY Baltimore	
14. FATHER'S NAME FIRST MIDDLE LAST Theodore ? Andriotis				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Angela Melisinos	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) UNKNOWN				16b. SOCIAL SECURITY NO. 172165770	
17. INFORMANT ADDRESS G. Hamamoto md Sinai Hosp.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Resp Arrest. 1889 } DUE TO, OR AS A CONSEQUENCE OF (b) CA Bladder - Systemic Candidiasis, Acute. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) Renal failure.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION 11/14/80		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Bladder Carcinoma		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE 11/27/80	
22. I certify that (I) (this hospital) attended the deceased from 11/14/80, 1980, to 11/27/80, 1980, that (I) (we) last saw the deceased alive on 11/27/80, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
23. SIGNATURE Gary Hamamoto md				23b. DATE SIGNED 11/27/80	
23a. PHYSICIAN'S NAME (TYPE OR PRINT) GARY HAMAMOTO MD				23c. ADDRESS Sinai Hosp. Baltimore	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-1-1980		23c. NAME OF CEMETERY OR CREMATORY Greek Orthodox	
23d. LOCATION CITY OR TOWN Baltimore		23e. COUNTY Maryland		23f. STATE	
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc.				25. DATE REC'D. BY REGISTRAR DEC 1 1980	
25a. ADDRESS 1050 York Road				25b. REGISTRAR'S SIGNATURE Ricky Helms	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8027802	
FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>HILOA ANSHEN</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>11-11-80</b>		2b. HOUR <b>3:55 P.M.</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>NOV. 12 1907</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> <del>72</del> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.					
10. CITY OR TOWN OF DEATH <b>BALTIMORE, MD.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b> 13b. COUNTY <b>BALTO.</b> 13c. CITY OR TOWN <b>BALTIMORE</b>						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>6996 MILBROOK PARK DR. #21215</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>ELLIS WHITEHEAD</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ANNA WOLFSON</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>212-09-3051</b>		17. INFORMANT <b>MR. BENNETT ANSHEN 6996 MILBROOK PARK DR., APT. 1B BALTO., MD 21215</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>LEFT VENTRICULAR INSUFFICIENCY / AORTIC STENOSIS</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>PNEUMONIC PLEUR</b> Approximate interval between onset and death: <b>Months</b> <b>3960</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Subacute Bacterial Endocarditis - Rupture of Mitral Valve</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>3/1</b> 19 <b>78</b> to <b>11/11</b> 19 <b>80</b> that (I) (we) last saw the deceased alive on <b>11/11</b> 19 <b>80</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated.											
22b. SIGNATURE <b>Barbara A. Cochran, M.D.</b> DEGREE <b>M.D.</b>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>11-11-80</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Barbara A. Cochran, M.D.</b>				22e. ADDRESS <b>6506 PARK HEIGHTS AVE.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>11/13/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BETH ISAAC ADATH ISRAEL</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>					
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b>				24b. ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 18 1980</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

*[Faint, mostly illegible text covering the majority of the page, likely bleed-through from the reverse side.]*

*[Handwritten signature or initials in the bottom left corner.]*

Dec 21/1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 0 2 7 8 0 3

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Minnie Anthony			2a. DATE OF DEATH MONTH DAY YEAR 11 17 80			2b. HOUR M	
3 SEX female		4 RACE B		5. DATE OF BIRTH MONTH DAY YEAR 4 30 95		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secours Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Factory worker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE md.				13b. COUNTY		13c. CITY OR TOWN Baltimore	
14. FATHER'S NAME FIRST MIDDLE LAST Jim Powell				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nora			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-34-3453		17. INFORMANT ADDRESS H. chart			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC arrest 1991 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <del>Failure of</del> liver metastatic (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH month week							
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): ASCVD - MS + CRF							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 16-05 78		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 10/17 1980			
22a. I certify that (I) (this hospital) attended the deceased from 10/17 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE M. M. M.		DEGREE MD		22c. DATE SIGNED 11/18/80		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARCELINO F. ALBUERNE MD		22e. ADDRESS 1940 W. Belts St Belk md 21223					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-22-80		23c. NAME OF CEMETERY OR CREMATORY Mount Vernon Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Randallstown Md.	
24. FUNERAL DIRECTOR NAME JAS. A. MORROW & SONS		ADDRESS 1701 LAWRENS		25a. DATE REC'D. BY REGISTRAR NOV 19 1980		25b. REGISTRAR'S SIGNATURE R. J. H. H. H.	

BP

DHMH-16 25M  
(VRA 15, 4) 1/79



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

217 8 0 4

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>CRAIG ADAMS ANTONINI</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>11 11 80</b>		2b. HOUR <b>1:30 AM</b>	
3. SEX <b>Male</b>		4. RACE <b>C</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>06 01 69</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>11</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MASS</b>		7b. CITIZEN OF WHAT COUNTRY? <b>US-</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Univ of Md Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Student</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b> 13b. COUNTY <b>Howard</b> 13c. CITY OR TOWN <b>Columbia</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>5126 DARTING BIRD LANE</b>	
14. FATHER'S NAME FIRST <b>Peter</b> MIDDLE <b>Antonic</b> LAST <b>Carroll</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Suzanne</b> MIDDLE <b>Carroll</b> LAST <b>Carroll</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Columbia, Md. 21045</b> <b>Mr. Peter Antonini, 5126 Darting Lane</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>4310</b> IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>massive hemorrhage - Extracranial</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic subdural hematoma</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 months</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <b>Hydrocephalus</b>							
19a. DATE OF OPERATION <b>11/11/80</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Chronic subdural hematoma</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>10/25</b> , 19 <b>80</b> , to <b>11/11</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>11/10</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>E. Botone</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>11/11/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>E. Botone</b>				22e. ADDRESS <b>Univ of Md Hospital - Neurology</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/14/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Dorsey, A.A., Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>5555 Twin Knolls Road, Columbia, Md</b> <b>Leroy M. &amp; Russell C. Witzke Columbia F.H.</b>				25. DATE REC'D. BY REGISTRAR <b>NOV 13 1980</b>		26. REGISTRAR'S SIGNATURE <b>Anthony M. Brady</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

100-100000-100000

INSTITUTIONAL

X

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1. STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 0 2 7 8 0 5

1. DECEASED NAME (TYPE OR PRINT) <b>Arthur R Arledge</b>			2a. DATE OF DEATH MONTH <b>11</b> DAY <b>22</b> YEAR <b>80</b>			2b. HOUR <b>1:05 PM</b>				
3. SEX <b>male</b>		4. RACE <b>black</b>		5. DATE OF BIRTH MONTH <b>12</b> DAY <b>15</b> YEAR <b>02</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Greenberry, N.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore</b> MD.				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Provident Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>retired</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Md.</b>			13b. COUNTY <b>Balto.</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>2600 Liberty Heights Ave.</b>			
14. FATHER'S NAME FIRST <b>Nichols</b> MIDDLE <b>Arledge</b> LAST <b></b>				15. MOTHER'S MAIDEN NAME FIRST <b>Missouri</b> MIDDLE <b></b> LAST <b>?</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>216-0 4-4571A</b>		17. INFORMANT <b>Emma Arledge</b>				ADDRESS <b>3604 Hillsdale</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>4860</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 22</b> 19 <b>80</b> to <b>Nov 22</b> 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>Nov 22</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Veita J. Brand, M.D.</b>						DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>11/22/80</b>		
22d. PHYSICIAN'S NAME (PRINT OR TYPE) <b>Veita J. Brand, M.D.</b>						22e. ADDRESS <b>2600 Liberty Heights</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>11/29/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Md. National Mem. Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME <b>Leroy O. Wright</b>			ADDRESS <b>4600 Liberty</b>			25a. DATE RECEIVED <b>NOV 25 1980</b>		25b. REGISTRAR'S SIGNATURE <b>R. Arledge</b>		

1000

*[Handwritten signature]*

NOV 2 1900

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 7 8 0 6

FOR  
1. STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ODELL ARNOLD</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11/7/1980</b>			2b. HOUR M <b></b>	
3. SEX <b>M</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 12 16</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Crownville MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1309 Myrtle Ave</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>As American</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Smoking</b>	
13a. STATE <b>MD</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Barbara Arnold</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Cornie Brown</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>250-18-7961</b>	
17. INFORMANT <b>W. N. Shell</b>		ADDRESS <b>Crownville MD</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic CV Disease</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Hypertension</b>							
19a. DATE OF OPERATION <b></b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b></b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b></b> <b></b> <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b></b>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b></b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b></b> <b></b> <b></b> <b></b>		22a. I certify that (I) (this hospital) attended the deceased from <b>July 1980</b> to <b>July 1980</b> , that (I) (we) lost the deceased alive on <b>July 1980</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.	
22b. SIGNATURE <b>G. Kingston</b>		DEGREE <b></b>		22c. DATE SIGNED <b>11/10/80</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>G. Kingston</b>	
22e. ADDRESS <b>848 HALLAM Ave</b>		23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		23b. DATE <b>11/12/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ANNUUS</b>	
23d. EDUCATION CITY OR TOWN <b>Baltimore MD 21227</b>		24. FUNERAL DIRECTOR NAME <b>W. Hall</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 12 1980</b>		25b. REGISTRAR'S SIGNATURE <b>P. H. H. H.</b>	

0. 1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

80 27807

REG. NO.

|  |  |   |  |  |  |   |  |                    |  |  |  |
|--|--|---|--|--|--|---|--|--------------------|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 2a. DATE OF DEATH                                       |  | MONTH  |  | DAY   |  | YEAR               |  | 2b. HOUR   |  |
| 1. DECEASED NAME   |  | FIRST   |  | MIDDLE   |  | LAST  |  | 11/3               |  | 80   |  |
| SHIRLEY  |  | M   |  | ARNOLD   |  |   |  |                    |  | 1:20 PM  |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | 7. IF UNDER 1 YEAR |  | 8. IF UNDER 24 HRS   |  |
| Female   |  | Black   |  | MONTH DAY YEAR   |  | 48 YRS  |  | MONTHS DAYS        |  | HOURS MIN  |  |
| 2. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?                            |  | 9. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 10. BALTIMORE CITY OR COUNTY OF DEATH                               |  |                    |  |  |  |
| MD   |  | USA   |  |  |  | Baltimore City  |  |                    |  | MD   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION |  | 12a. USUAL OCCUPATION  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                    |  |  |  |
| Baltimore  |  | University Hospital                                     |  | (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |   |  |                    |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13b. INSIDE CITY LIMITS?                                |  | 13c. STREET ADDRESS  |  |   |  |                    |  |  |  |
| 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 2546 McCulloh St.  |  |  |  |
| MD   |  |   |  | Baltimore  |  |   |  |                    |  |  |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME                                |  |  |  |   |  |                    |  |  |  |
| FIRST MIDDLE LAST  |  | FIRST MIDDLE LAST                                       |  |  |  |   |  |                    |  |  |  |
| Lancaster  |  | Hill  |  | Genevieve  |  | West  |  |                    |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO                                 |  | 17. INFORMANT  |  | ADDRESS   |  |                    |  |  |  |
| NO   |  | 215-28-2873   |  | Walter Arnold  |  | 2546 McCulloh St.   |  |                    |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):)  |  | 19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH        |  |  |  |   |  |                    |  |  |  |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)  |  | Probable pulmonary embolism                             |  |  |  |   |  |                    |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost  |  | DUE TO, OR AS A CONSEQUENCE OF (b)                      |  | Prolonged bed rest, total hip replacement  |  |   |  |                    |  |  |  |
|  |  | DUE TO, OR AS A CONSEQUENCE OF (c)                      |  | Multiple metastasis to brain, pelvis, femur  |  |   |  |                    |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):               |  | As above  |  |  |  |   |  |                    |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED        |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |                    |  |  |  |
|  |  | Hip replacement   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |                    |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY                                     |  | 21c. HOW INJURY OCCURRED   |  | (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |  |                    |  |  |  |
|  |  | HOUR A.M. MONTH DAY YEAR                                |  |  |  |   |  |                    |  |  |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY                                    |  | 21f. LOCATION  |  |   |  |                    |  |  |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)          |  | STREET   |  | CITY OR TOWN  |  | COUNTY             |  | STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from   |  | 10/7/80   |  | 19   |  | to 11/3   |  | 1980               |  | that (I) (we) last saw the deceased alive on   |  |
|  |  | 11/3  |  | 19   |  | 80  |  |                    |  | and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |
| 22b. SIGNATURE   |  | DEGREE  |  | 22c. DATE SIGNED   |  |   |  |                    |  |  |  |
| Rajaram  |  |   |  | 11/3/80  |  |   |  |                    |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS  |  |  |  |   |  |                    |  |  |  |
| RAJARAM  |  |   |  |  |  |   |  |                    |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  | COUNTY             |  | STATE  |  |
| Burial   |  | 11/6/80   |  | Crownsville VA Cen.  |  | Crownsville   |  | MD                 |  |  |  |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE REC'D. BY REGISTRAR                           |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |                    |  |  |  |
| NAME ADDRESS   |  | NOV 5 1980  |  | L. J. H. H. H.   |  |   |  |                    |  |  |  |
| Wm. C. March F/H   |  | 1101 E. North Ave.                                      |  |  |  |   |  |                    |  |  |  |

BP

DHMH-16 25M  
(VRA 15, 4) 1/79

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of the law should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 10 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |   |  |  |  |   |  |  |  |   |  |   |  |  |  |  |  |                                |  |  |  |                      |  |  |  |                  |  |  |  |
|---|--|--|--|---|--|--|--|---|--|--|--|---|--|--|--|---|--|---|--|--|--|--|--|--------------------------------|--|--|--|----------------------|--|--|--|------------------|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  |  | FIRST<br>Dorothy  |  |  |  | MIDDLE<br>Artis   |  |  |  | LAST  |  |  |  | 2a. DATE KNOWN<br>OF<br>DEATH<br>ESTI-<br>MATED |  |   |  | <input checked="" type="checkbox"/> MONTH<br>DAY<br>YEAR |  |  |  | 7b. HOUR<br>M                  |  |  |  |                      |  |  |  |                  |  |  |  |
| SEX<br>Female   |  |  |  | 4. RACE<br>Black  |  |  |  | 5. DATE OF BIRTH<br>MONTH<br>DAY<br>YEAR  |  |  |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)<br>60 YRS.   |  |  |  | IF UNDER 1 YR.<br>MONTHS<br>DAYS                |  |   |  | IF UNDER 24 HRS.<br>HOURS<br>MIN.                        |  |  |  | 7c. DATE<br>PRONOUNCED<br>DEAD |  |  |  | MONTH<br>DAY<br>YEAR |  |  |  | 7d. HOUR<br>P.M. |  |  |  |
| BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)<br>Md.   |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City  |  |  |  | MD.   |  |   |  |  |  |  |  |                                |  |  |  |                      |  |  |  |                  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Maryland General Hospital |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)  |  |  |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY  |  |  |  |   |  |   |  |  |  |  |  |                                |  |  |  |                      |  |  |  |                  |  |  |  |
| 13a. STATE<br>Md.   |  |  |  | 13b. COUNTY   |  |  |  | 13c. CITY OR TOWN<br>Balto.   |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  | 13e. STREET ADDRESS<br>614 Cumberland St.       |  |   |  |  |  |  |  |                                |  |  |  |                      |  |  |  |                  |  |  |  |
| 14. FATHER'S NAME<br>FIRST<br>Unkn  |  |  |  | MIDDLE  |  |  |  | LAST  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST<br>Estella  |  |  |  | MIDDLE  |  |   |  | LAST<br>Watkins  |  |  |  |                                |  |  |  |                      |  |  |  |                  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No   |  |  |  | (IF YES, GIVE WAR OR DATES)   |  |  |  | 16b. SOCIAL SECURITY NO.<br>215-12-1664   |  |  |  | 17. INFORMANT<br>James R. Artis   |  |  |  | ADDRESS<br>614 Cumberland Ave.                  |  |   |  |  |  |  |  |                                |  |  |  |                      |  |  |  |                  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease<br>4292 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which }<br>gave rise to immediate }<br>cause (a) stating the under- }<br>lying cause last. }<br>(b) }<br>DUE TO, OR AS A CONSEQUENCE OF }<br>(c) }  |  |  |  |   |  |  |  |   |  |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                     |  |  |  |  |  |                                |  |  |  |                      |  |  |  |                  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |  |  |   |  |  |  |   |  |  |  |   |  |  |  |   |  |   |  |  |  |  |  |                                |  |  |  |                      |  |  |  |                  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |   |  |  |  |   |  |  |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |                                |  |  |  |                      |  |  |  |                  |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |   |  |  |  |   |  |   |  |  |  |  |  |                                |  |  |  |                      |  |  |  |                  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)  |  |  |  | 21f. LOCATION<br>STREET   |  |  |  | CITY OR TOWN  |  |  |  | COUNTY  |  |   |  | STATE  |  |  |  |                                |  |  |  |                      |  |  |  |                  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion<br>death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |  |  |   |  |  |  |   |  |  |  |   |  |  |  |   |  |   |  |  |  |  |  |                                |  |  |  |                      |  |  |  |                  |  |  |  |
| ACTUAL<br>SIGNATURE<br>Margarita A. Korell, M.D.  |  |  |  | TITLE (SPECIFY)<br>Assistant  |  |  |  | MEDICAL EXAMINER  |  |  |  | DATE<br>SIGNED<br>11-14-80  |  |  |  |   |  |   |  |  |  |  |  |                                |  |  |  |                      |  |  |  |                  |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)  |  |  |  | Margarita A. Korell, M.D.   |  |  |  | ADDRESS<br>111 Penn Street  |  |  |  |   |  |  |  |   |  |   |  |  |  |  |  |                                |  |  |  |                      |  |  |  |                  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |  |  | 23b. DATE<br>11/19/80   |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>King Mem. Pk.   |  |  |  | 23d. LOCATION<br>CITY OR TOWN<br>Baltimore Co., Md.   |  |  |  | COUNTY<br>STATE                                 |  |   |  |  |  |  |  |                                |  |  |  |                      |  |  |  |                  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm C March F/H  |  |  |  | ADDRESS<br>1101 E. North Ave.   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 19 1980  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br>Ricky Melnyk  |  |  |  |   |  |   |  |  |  |  |  |                                |  |  |  |                      |  |  |  |                  |  |  |  |

10-11-11

10-11-11

10-11-11

10-11-11

10-11-11

10-11-11

10-11-11

10-11-11

10-11-11

10-11-11

10-11-11

10-11-11

10-11-11

10-11-11

10-11-11



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80

27809

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |   |  |  |
|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Amanda Ashford</b>   |   |   | 2a. DATE OF DEATH<br>MONTH <b>NOVEMBER</b> DAY <b>5</b> YEAR <b>1980</b>                        |  | 2b. HOUR<br><b>7:35P.M.</b>  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>black</b>   | 5. DATE OF BIRTH<br>MONTH <b>10</b> DAY <b>3</b> YEAR <b>1981</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS.                              | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>5 Carolina U.S.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>City</b> MD.                        |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltos.</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Bon Secours</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>retired</b>              |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br><b>MD</b>   | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>2040 Harlem Avenue</b>                               |  |
| 14. FATHER'S NAME<br>FIRST <b>Clay</b> MIDDLE LAST <b>BETH</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Mattie</b> MIDDLE LAST <b>Grubbs</b>   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>705 10 9160</b>  |   | 17. INFORMANT<br><b>Carol J. Ashford</b> ADDRESS<br><b>2040 Harlem Ave.</b>    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>So. Ventricular Fibrillation and Asystole</b><br><b>4280</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Intractable Congestive Heart Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |   |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |   |   |   |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |   |   |   |  |  |
| 22b. SIGNATURE<br><b>Winston Hugh Williams MD</b>   |   | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>11/5/80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>WINSTON Hugh Williams MD</b>  |   | 22e. ADDRESS<br><b>c/o Bon Secours Hospital Dept. of Medicine</b>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   | 23b. DATE<br><b>11-10-80</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MD Nat Cemetery</b>  |   | 23d. LOCATION<br>CITY OR TOWN <b>Laurel</b> COUNTY <b>MD</b> STATE <b>MD</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Clas. H. Powell F/A</b> ADDRESS <b>319 N. Schroeder</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 12 1980</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                               |  |

November 1925

October 1925

September 1925

August 1925

July 1925

June 1925

May 1925

April 1925

March 1925

February 1925

January 1925

11/2/25

11/2/25

11/2/25

11/2/25

11/2/25

11/2/25

RELEASED AS NON-MED BY MEO

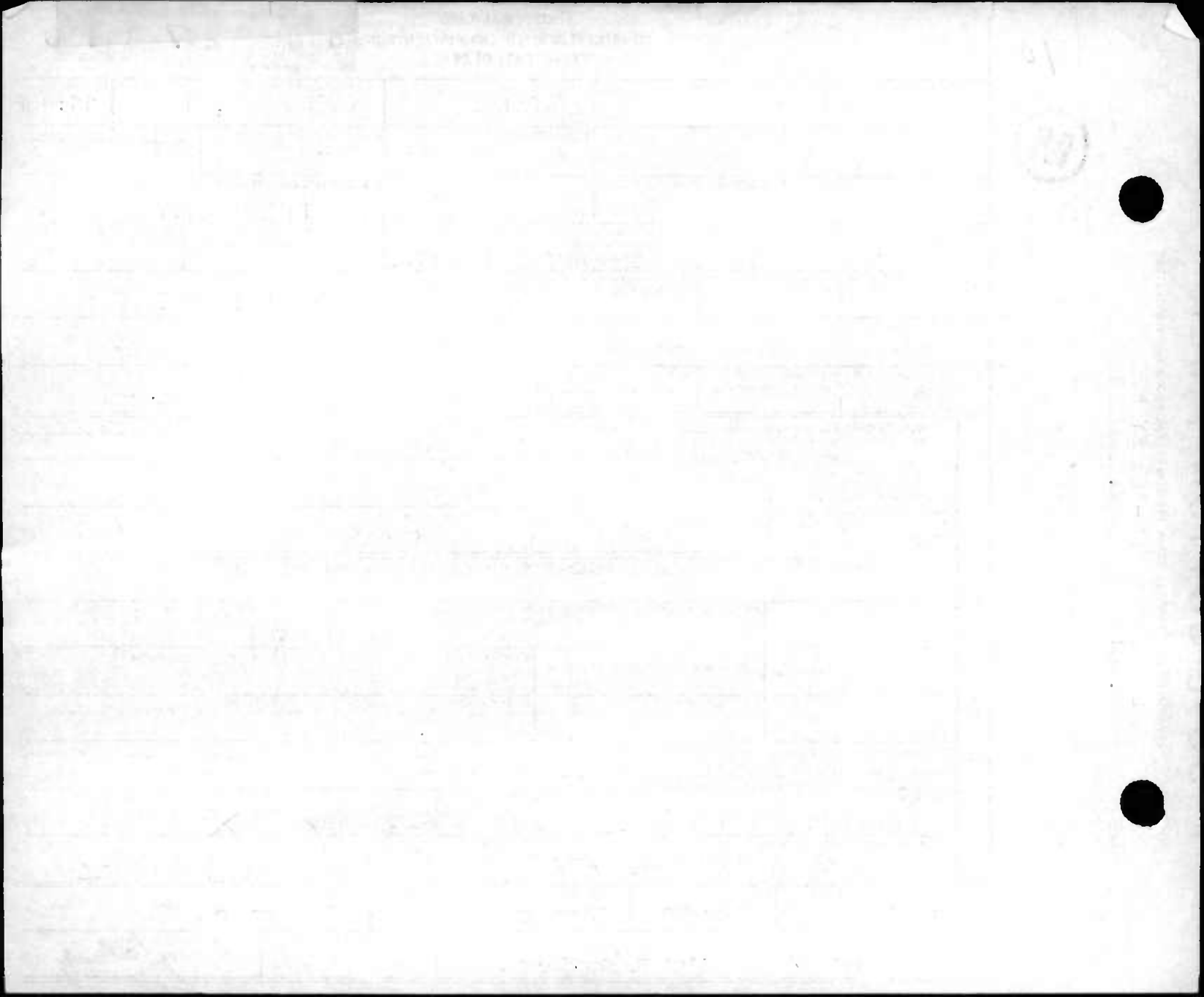
TO HOSPITAL OR ATTENDING PHYSICIAN, IN CASE OF NON-MEDICAL DEATH, THIS CERTIFICATE MUST BE RETURNED TO THE DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201.

TO HOSPITAL OR ATTENDING PHYSICIAN, IN CASE OF MEDICAL DEATH, THIS CERTIFICATE MUST BE RETURNED TO THE DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |  |                       | REG. NO. 80 27810  |  |
|---|--|---|--|---|--|---|--|--|-----------------------|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   |  |   |  |  |                       |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>LILLIE ATKINS  |  |   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>NOVEMBER 5, 1980  |  |  | 2b. HOUR<br>11:48 P M |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Black  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>7 23 15  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br>65  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |                       |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |  |  |                       |  |  |
| 10. CITY OR TOWN OF DEATH<br>Balto.   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY  |                       |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   |  |   |  |  |                       |  |  |
| 13a. STATE<br>Md.   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>4018 Bateman Ave.   |                       |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Walter E. Johnson  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Willie Jane Phelps  |  |   |  |  |                       |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) No   |  |   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES) 215-18-6177   |  | 17. INFORMANT ADDRESS<br>Adell C. Gladden 4018 Bateman Ave.                                     |  |  |                       |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Intubation Hypoxia</u><br>4100 } DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Pulmonary Edema / Shock</u><br>(c) <u>Myocardial Infarction</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1/2 day<br>1/2 day |  |   |  |   |  |   |  |  |                       |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |   |  |  |                       |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |  |                       |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |                       |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/5/80</u> , 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on <u>11/5/80</u> , 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |  |                       |  |  |
| 22b. SIGNATURE<br><u>Kenneth Roulstaden</u>   |  |   |  | DEGREE<br>MD  |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                       | 22c. DATE SIGNED<br>11/5/80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>KENNETH ROULSTADEN   |  |   |  | 22e. ADDRESS<br>JOHNS HOPKINS HOSPITAL  |  |   |  |  |                       |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |   |  | 23b. DATE<br>11/10/80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>King Mem. Pk.   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore Co., Md.  |                       |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Wm C. March F/H  |  |   |  |   |  | ADDRESS<br>1101 E. North Ave.   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 10 1980   |                       | 25b. REGISTRAR'S SIGNATURE<br><u>Harry Mahoney</u>   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8027811

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 1- STATE REGISTRAR   |  | FOR  |  | REG. NO.   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><i>Viola A. Atkins</i>   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>Nov. 4, 1980</i>  |  | 2b. HOUR MIN.<br><i>11:15 AM</i>   |  |
| 3. SEX<br><i>Female</i>  | 4. RACE<br><i>Black</i>  | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>Feb. 8, 1891</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br><i>89 YRS.</i>                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Alabama</i>  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.                            |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>John D. Spaton Medical Center</i> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Hotel Worker</i> |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br><i>Maryland</i>  |  | 13b. COUNTY<br><i>Baltimore</i>  | 13c. CITY OR TOWN<br><i>Baltimore</i>  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><i>3000 A. Reisterstown Rd. Balto.</i>                                      |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>Sidney Dubose</i>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Nettie Edwards</i>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><i>No</i>   |  | 16b. SOCIAL SECURITY NO.<br><i>383-18-3651</i>   |  | 17. INFORMANT ADDRESS<br><i>Catherine Gross, Same as above</i>                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Septic</i><br>436° } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Multiple ruptured decubiti</i><br>(c) <i>CCA &amp; Hemiplegia</i> |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>2 days</i><br><i>3 weeks</i><br><i>3 months</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><i>19</i>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)               |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (a) (this hospital) attended the deceased from <i>10/27/80</i> to <i>11/4/80</i> , that (we) last saw the deceased alive on <i>11/4/80</i> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (a) (we) (did) (do not) view the body after death.  |  |  |  |  |  |
| 22b. SIGNATURE<br><i>JR. Gladey, MD</i>  |  | DEGREE<br><i>MD</i>  |  | 22c. DATE SIGNED<br><i>10/31/80</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Cremation</i>  |  | 23b. DATE<br><i>Nov. 3, 1980</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Security Process Crem.</i>                          |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE<br><i>Baltimore Co. Maryland</i>   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><i>McCutty Funeral Home, 130 E. Forest Ave. Balto. Md.</i>   |  | 25a. DATE REC'D. BY REGISTRAR<br><i>NOV 5 1980</i>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Larry K. K...</i>   |  |

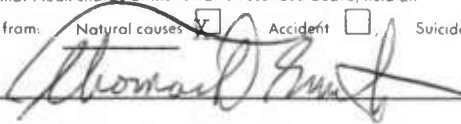



UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

*[Faint, mostly illegible handwritten text on lined paper. The text appears to be a letter or report, possibly related to plant industry or agriculture, given the header. Some words like "Bureau of Plant Industry" and "Washington, D. C." are faintly visible.]*

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                  |  |  |  |   |  |   |  | REG. NO. 0 2 7 8 1 2   |  |
|--|--|------------------|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |                  |  |  |  |   |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Henry Avery  |  |                  |  |  |  |   |  |   |  | 2a. DATE KNOWN OF DEATH ESTI MATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br>11 9 1980               |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Black |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.  |  | IF UNDER 1 YR. MONTHS DAYS  |  | IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore City  |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Maryland General Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY      |  | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>1606 McCulloh Street   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>John Avery  |  |                  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Sadie Darden   |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |  |                  |  | 16b. SOCIAL SECURITY NO.   |  |   |  | 17. INFORMANT ADDRESS<br>Rufus J. Avery 1541 Woodburne Avenue   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>5715 IMMEDIATE CAUSE (a) <u>Cirrhosis of liver &amp; diabetes mellitus</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |                  |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                 |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)     |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                  |  |  |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE    |  |                  |  | TITLE (SPECIFY)<br>M. Deputy Chief, MEDICAL EXAMINER   |  |   |  | DATE SIGNED 11/10/80  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Thomas D. Smith, M.D.   |  |                  |  | ADDRESS<br>111 Penn St. Balto., MD.  |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |                  |  | 23b. DATE<br>11/15/80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>King Memorial Park                          |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore MD   |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>WILLIAM C. MARCH FUNERAL HOME INC.  |  |                  |  | ADDRESS<br>1101 E. North Ave   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 12 1980  |  | 25b. REGISTRAR'S SIGNATURE  |  |

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

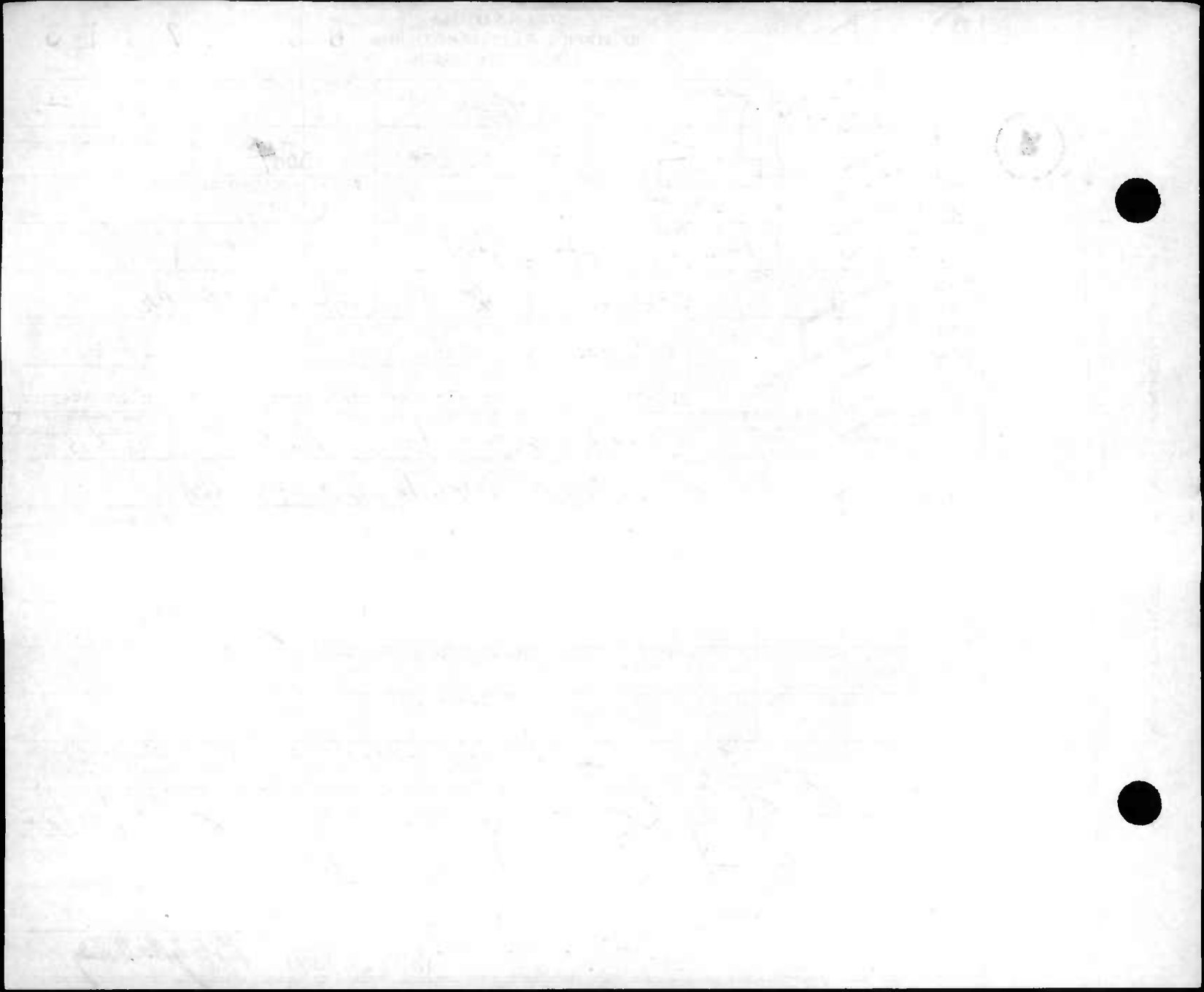
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |              |  |  |  |  |
|--|--------------|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>FLORENCE E. AYERS  |              | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 14 80  |  | 2b. HOUR<br>11:25 P.M.   |  |
| 3. SEX<br>F  | 4. RACE<br>B | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7 18 26  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>54 YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |              | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>CITY MD                                      |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |              | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Lutheran Hospital                       |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |  |
| 13a. STATE<br>Maryland   |              | 13b. COUNTY  |  | 13c. STREET ADDRESS<br>1546 Harlem Ave   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>James E. Washington  |              | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Edna Jennings   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |              | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>220-12-5855   |  | 17. INFORMANT<br>ADDRESS<br>Rozella Barbara Mccray 1946 Harlem Avenue                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiorespiratory Arrest<br>2500<br>DUE TO, OR AS A CONSEQUENCE OF (b) Diabetes Mellitus - Out of Control<br>DUE TO, OR AS A CONSEQUENCE OF (c) Acute Blood Tox<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>4 1/2 |              |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |              |  |  |  |  |
| 19a. DATE OF OPERATION   |              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |              | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |              | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/14, 19 80, to 11/15, 19 80, that (I) (we) lost saw the deceased alive on 11/14, 19 80, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                      |              |  |  |  |  |
| 22b. SIGNATURE<br>Michael H. Blumenn   |              | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>11/14/80   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Michael H. Blumenn  |              | 22e. ADDRESS<br>Lutheran Hospital  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |              | 23b. DATE<br>11/19/80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>King Memorial Park                             |  |
| 23d. LOCATION<br>CITY OR TOWN<br>Baltimore   |              | COUNTY<br>Co.  |  | STATE<br>MD  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>WILLIAM C. MARCH FUNERAL HOME INC.   |              | ADDRESS<br>1101 E. North Ave.  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 19 1980   |  |
|  |              |  |  | 25b. REGISTRAR'S SIGNATURE<br>Rozella Barbara Mccray                                 |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 27814

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |                                       |  |
|---|--|---|--|---|---------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Rose Lee Badgett</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 15, 1980</b>          |   | 2b. HOUR<br><b>6:25P</b> M            |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Negro</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 27, 1896</b>                  |                                       |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>S.C.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b><br>YRS. MONTHS DAYS HOURS MIN. |                                       |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.           |                                       |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |                                       |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b> |  |   | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Baltimore</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Ned Taylor</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Patience Jenkins</b> |   |                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>579-44-7862-A</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Rozenia Wright, 115 No. Bentalou St.</b>     |                                       |  |

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Sepsis</b>  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                      |  |
| 7070<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Decubitus</b>                               |  |
|   |  |  |  | DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Cerebro Vascular Accident</b>   |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>October 28, 1980</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Dysphagic-Feeding Gastrostomy</b> |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (1) this hospital attended the deceased from <b>October 21, 1980</b> to <b>November 15, 1980</b> , that (we) last saw the deceased alive on <b>November 15, 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. |  |  |  |  |  |
| 22b. SIGNATURE<br><i>Wiley A. Patterson</i>   |  | DEGREE<br><b>Wiley A. Patterson M.D.</b>   |  | 22c. DATE SIGNED<br><b>11-16-80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Wiley A. Patterson M.D.</b>   |  | 22e. ADDRESS<br><b>Care of Maryland General Hospital</b>                                 |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>11-21-80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lincoln Memorial Cem.</b>                   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Suitland, Md.</b>  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Marshall's Funeral Home<br/>4217 9th St. N.W., Washington, D.C.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 19 1980</b>                                      |  | 25b. REGISTRAR'S SIGNATURE<br><i>Patricia McCreedy</i>                               |  |





10  
97  
42  
35  
300  
1  
9  
9  
1

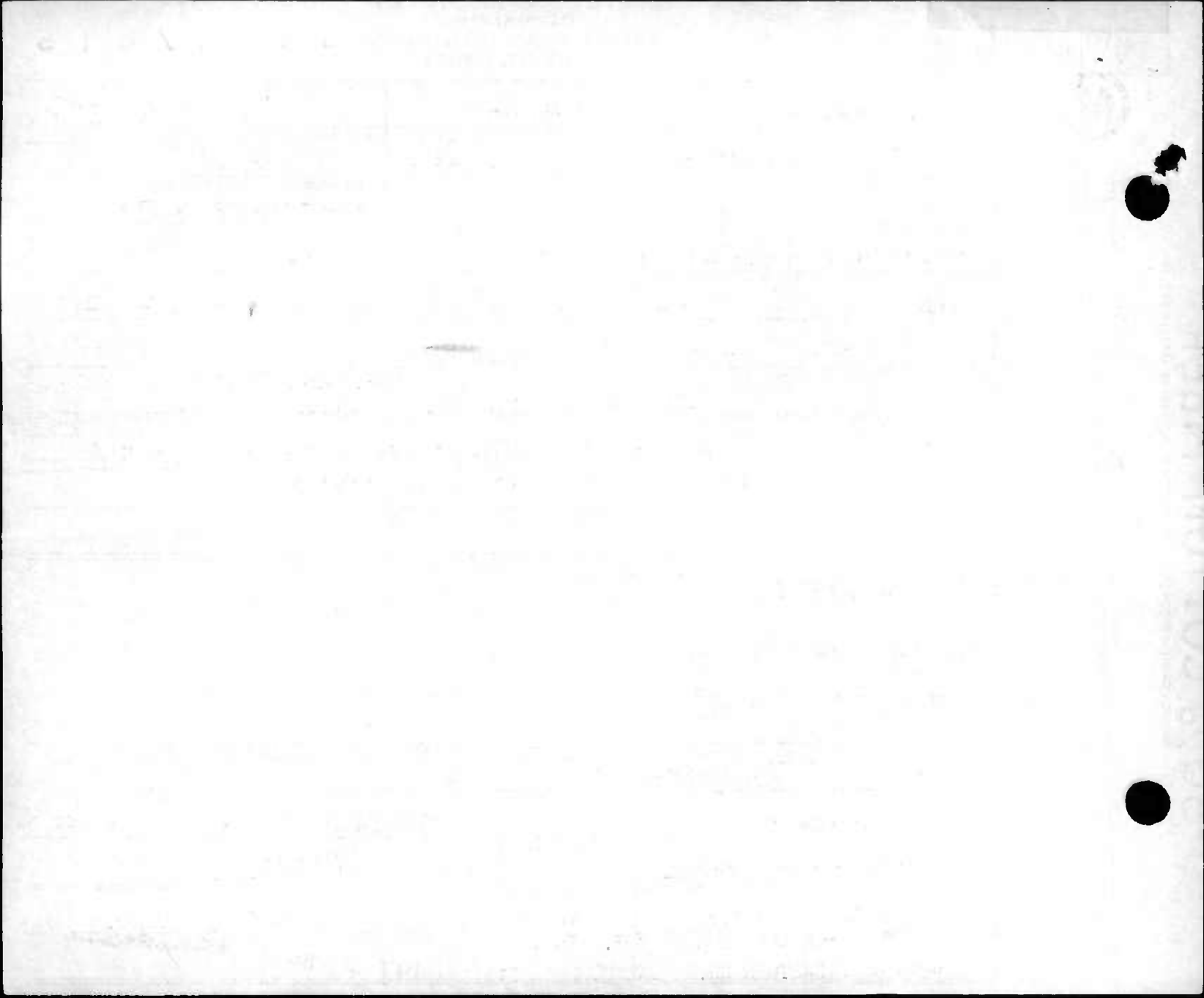
272 BP  
DHMH-16 30M 2/80  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 0 2 7 8 1 5   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>REV. AARON BAIDA  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 30 80   |  | 2b. HOUR<br>2 <sup>25</sup> P M  |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 28 1919   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>80 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>POLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SINAI HOSPITAL |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>CATERER   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>FOOD  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD   |  |   |  | 13b. COUNTY<br>BALTIMORE  |  | 13c. CITY OR TOWN<br>BALTIMORE   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>SHMUEL ZEV SCHMULOWITZ   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>NANSHA BROCHA UNKNOWN   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>213 342532   |  | 17. INFORMANT<br>MRS. MARGOT ZIPPER 3608 GARDEN-<br>VIEW RD. BALTO., MD 21208   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION CLASS IV<br>4100<br>DUE TO, OR AS A CONSEQUENCE OF (CAPNOGENIC SHOCK)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) _____<br>(c) _____ |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>6 HRS   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>DIABETES  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-30 1980, to 11-30 1980, that (I) (we) lost<br>saw the deceased alive on 11-30 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                    |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Goldberg   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br>11-30-80   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>GOLDBERG JORGE  |  |   |  | 22e. ADDRESS<br>SINAI HOSPITAL  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) BURIAL  |  | 23b. DATE<br>12/1/80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>CHEVRA AHAVAS CHESD   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>RANDALLSTOWN BALTO MD  |  |
| 24. FUNERAL DIRECTOR<br>NAME SOL LEVINSON & BROS., INC.<br>ADDRESS 6010 REISTERSTOWN RD. BALTO. MD 21215   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 3 1980   |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |



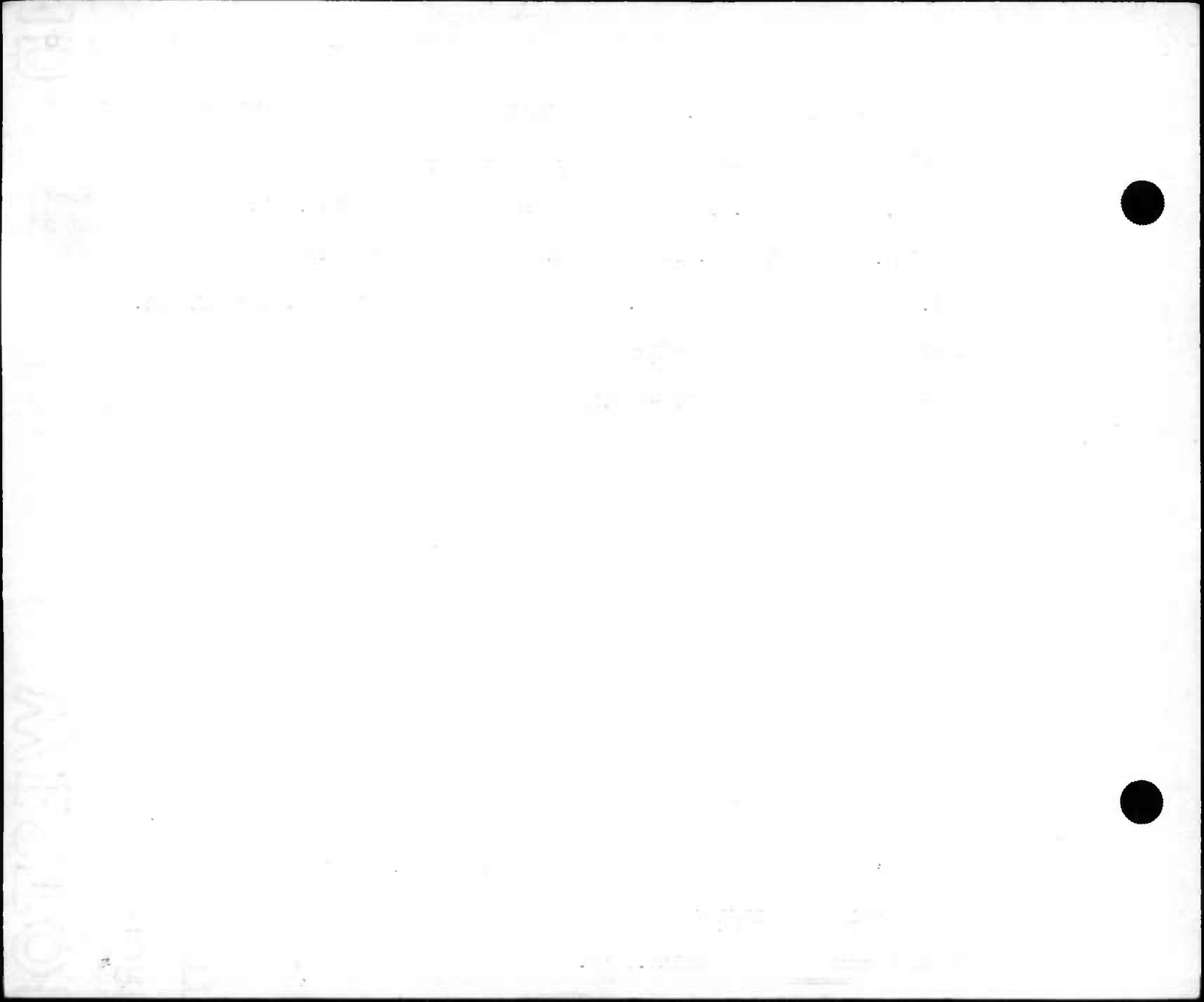
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 7 8 1 6

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |  |  |   |                                    |  |  |  |  |  |  |
|---|--|--|--|---|------------------------------------|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>GEORGE W. BAILEY</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 10 80</b>                 |   | 2b. HOUR<br><b>10:00</b><br>A M    |  |  |  |  |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 25 97</b>  |                                    | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b> YRS                                     |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>0 0</b>  |  | 8. IF UNDER 24 HRS<br>HOURS MIN.<br><b>0 0</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b> MD.                       |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1602 N. Rosedale St.</b> |  |   |                                    | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Janitor</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |                                    | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1602 N. Rosedale St.</b>   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Frank Bailey</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Emma</b>  |                                    |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br><b>229-10-3109</b>   |  | 17. INFORMANT<br>ADDRESS  |                                    |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac-Respiratory Arrest</u><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <u>Chronic Hypoxia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Sp Pneumothorax - Lung Cancer</u> |  |  |  |   |                                    |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>minutes</u><br><b>3 yrs</b><br><b>3 years</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):<br><b>0</b>  |  |  |  |   |                                    |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |                                    | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>June</u> 19 <u>80</u> to <u>August</u> 19 <u>80</u> , that (1) (we) lost<br>saw the deceased alive on <u>August</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (1) (we) (did) (did not) view the body after death.   |  |  |  |   |                                    |  |  |  |  |  |  |
| 22b. SIGNATURE<br><u>James A. Quinlan MD</u>  |  |  |  |   |                                    | DEGREE<br><b>MD</b>  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11/11/80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JAMES A. QUINLAN JR MD</b>  |  |  |  |   |                                    | 22e. ADDRESS<br><b>University Hospital</b>   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Removal</b>  |  |  | 23b. DATE<br><b>11/10/80</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Anatomy Board</b>  |  |  |  |   |                                    | ADDRESS<br><b>Balto., Md.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 17 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Robert McCondy</u>  |  |





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 27817

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| FOR<br>1 - STATE<br>REGISTRAR   |  | 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | 2a. DATE OF DEATH   |  | 2b. HOUR   |  |
|   |  | FIRST MIDDLE LAST<br><i>James A. Bailey</i>  |  | MONTH DAY YEAR<br><i>11-1-80</i>  |  | 6 a.m.   |  |
| 3. SEX<br><i>Male</i>   |  | 4. RACE<br><i>Negro</i>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>10 29 11</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><i>69</i>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>VA</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>BALTIMORE CITY</i> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><i>BALTIMORE</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>ST. AGNES HOSPITAL</i> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><i>MD</i>   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><i>Baltimore</i>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 13e. STREET ADDRESS<br><i>5112 Fredcrest Rd.</i>  |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Stephen Bailey</i>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Lizzie</i>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>NO</i>   |  | 16b. SOCIAL SECURITY NO.<br><i>217-07-8871</i>   |  | 17. INFORMANT<br>ADDRESS<br><i>Lucy Bailey 5112 Fredcrest Rd.</i>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>CARDIO RESPIRATORY ARREST</i><br><i>5715</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>HEPATO RENAL SYNDROME</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>CIRRHOSIS OF THE LIVER</i> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>5 minutes</i><br><i>4 DAYS</i><br><i>2 mos</i>                                      |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><i>UPPER GI BLEEDING, ANTEROLATERAL MYOCARDIAL INFARCTION</i>  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <i>19</i>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><i>[Signature]</i>  |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                             |  | 22c. DATE SIGNED<br><i>11/1/80</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>ANASTASIO R. DE CASTRO</i>  |  | 22e. ADDRESS<br><i>900 S. CATON AVE. BALTO., MD/<br/>ST. AGNES HOSP. 21229</i>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>  |  | 23b. DATE<br><i>11/5/80</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Cedar Hill Cem.</i>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Baltimore Co. MD</i>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Wm. C. March F/H</i>   |  | ADDRESS<br><i>1101 E. North Ave.</i>   |  | 25a. DATE REC'D. BY REGISTRAR<br><i>NOV 5 1980</i>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |



BALTIMORE CITY

JANUARY 1942

1942

1942

1942

1942

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMM-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 7 8 1 8

REG. NO.

|  |  |  |  |   |  |  |   |  |
|--|--|--|--|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>DONALD M. BAIN</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 30 80</b>                 |   | 2b. HOUR<br><b>10:50 A</b>               |  |   |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 01 02</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS.  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MASS</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>       |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. AGNES HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>WIREMAN</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Westinghouse</b>   |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>  |  |  | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Arbutus</b>      |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Peter Bain</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary A. Sheard</b> |   | 16. ADDRESS<br><b>Ellicott City, Md.</b> |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW 11</b>  |  | 17. INFORMANT<br><b>Martha L. Mitchell</b>  |  | 18. ADDRESS<br><b>2925 Summit Circle</b>   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Ruptured aortic Aneurysm, Shock</b><br><b>4413</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>cardiac failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>renal failure</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |  |   |  |
| 19a. DATE OF OPERATION<br><b>11/29/80</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Ruptured aortic Aneurysm</b>  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/29/80</b> 19 <b>80</b> to <b>11/30/80</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>11/29</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |   |  |
| 22b. SIGNATURE<br><b>B. Parandian</b>  |  |  |  | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11/5/80</b>   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>B. PARANDIAN</b>   |  |  |  | 22e. ADDRESS<br><b>ST. AGNES HOSPITAL 900 S. CATON AVENUE</b>   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>12/2/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Hubbard Funeral Home, Inc. 4107 Wilkens Avenue</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 10 1980</b>   |  |  |   |  |
| 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |  |  |   |  |  |   |  |



BALTIMORE CITY

DATE  
TIME

ST. JOSEPH HOSPITAL

REPORT

NO. 1000

DATE

TIME

PLACE

REMARKS

DESCRIPTION

TESTS

RESULTS

DISCUSSION

CONCLUSIONS

SIGNATURE

DATE

TIME

PLACE

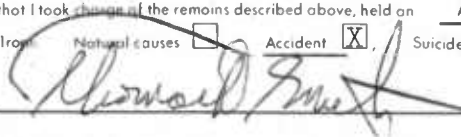
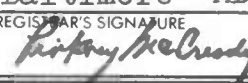
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH-17  
(VR A15 ME (5))  
15M2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

|   |             |  |                   |   |   |   |  |   |   |   |                               |           |
|---|-------------|--|-------------------|---|---|---|--|---|---|---|-------------------------------|-----------|
| DECEASED NAME<br>(TYPE OR PRINT)  |             |  | FIRST             | MIDDLE  | LAST  | 2a. DATE KNOWN OF DEATH   |  |   | <input checked="" type="checkbox"/> MONTH | <input type="checkbox"/> DAY  | <input type="checkbox"/> YEAR | 2b. HOUR  |
| Iris Lourine Baker  |             |  |                   |   |   | 11 10 80  |  |   |   |   |                               | M         |
| SEX   | 4. RACE     | 5. DATE OF BIRTH   | 6. AGE (IN YEARS) | IF UNDER 1 YR.  | IF UNDER 24 HRS.  | 2c. DATE PRONOUNCED DEAD  |  |   | MONTH                                     | DAY   | YEAR                          | 2d. HOUR  |
| Female  | White       | 10 16 1962   | 18 YRS.           |   |   | 11 10 80  |  |   |   |   |                               | 1:05 A.M. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |             | 7b. CITIZEN OF WHAT COUNTRY?   |                   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |   |   |   |                               |           |
| Maryland  |             | U.S.A.   |                   |   |   | Baltimore City,   |  |   | MD.                                       |   |                               |           |
| 10. CITY OR TOWN OF DEATH   |             | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN THIS FACILITY, GIVE STREET ADDRESS) |                   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |   |   |                               |           |
| Baltimore City  |             | University Hospital  |                   |   | Waitress  |   |  |   |   |   |                               |           |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |             |  |                   |   |   |   |  |   |   |   |                               |           |
| 13a. STATE  | 13b. COUNTY | 13c. CITY OR TOWN  |                   | 13d. INSIDE CITY LIMITS?  |   | 13e. STREET ADDRESS   |  |   |   |   |                               |           |
| Maryland  | Baltimore   | Dundalk  |                   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 219 Parkwood Road   |  |   |   |   |                               |           |
| 14. FATHER'S NAME   |             |  |                   | 15. MOTHER'S MAIDEN NAME  |   |   |  |   |   |   |                               |           |
| Dorman S. Baker   |             |  |                   | Betty I. Vance  |   |   |  |   |   |   |                               |           |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)   |             |  |                   | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT   |  |   |   |   |                               |           |
| No  |             |  |                   | 213-54-4447   |   | Dorman S. Baker Balto. Md. 21222  |  |   |   |   |                               |           |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:  |             |  |                   |   |   |   |  |   |   |   |                               |           |
| IMMEDIATE CAUSE (a) <u>Fractured neck with transection of spinal cord</u>   |             |  |                   |   |   |   |  |   |   |   |                               |           |
| DUE TO, OR AS A CONSEQUENCE OF  |             |  |                   |   |   |   |  |   |   |   |                               |           |
| (b) _____   |             |  |                   |   |   |   |  |   |   |   |                               |           |
| DUE TO, OR AS A CONSEQUENCE OF  |             |  |                   |   |   |   |  |   |   |   |                               |           |
| (c) _____   |             |  |                   |   |   |   |  |   |   |   |                               |           |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |             |  |                   |   |   |   |  |   |   |   |                               |           |
| 19a. DATE OF OPERATION  |             |  |                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |   |  |   |   | 20. AUTOPSY?  |                               |           |
|   |             |  |                   |   |   |   |  |   |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                               |           |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |             |  |                   | 21b. TIME OF INJURY<br>HOUR <u>11:55</u> MONTH <u>11</u> DAY <u>9</u> YEAR <u>80</u>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |   |   |                               |           |
|   |             |  |                   |   |   | passenger in auto/fixed object impact   |  |   |   |   |                               |           |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>  |             |  |                   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |   | 21f. LOCATION<br>STREET   |  | CITY OR TOWN  |   | COUNTY STATE  |                               |           |
|   |             |  |                   | street  |   | Ritchie Hwy & Orchard Rd.   |  | A.A. Co.,   |   | MD.   |                               |           |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |             |  |                   |   |   |   |  |   |   |   |                               |           |
| ACTUAL SIGNATURE  |             |  |                   | TITLE (SPECIFY)   |   |   |  | DATE SIGNED   |   |   |                               |           |
|    |             |  |                   | M.D. Deputy Chief   |   |   |  | 11/10/80  |   |   |                               |           |
| EXAMINER'S NAME<br>(TYPE OR PRINT)  |             |  |                   | ADDRESS   |   |   |  |   |   |   |                               |           |
| Thomas D. Smith, M.D.   |             |  |                   | 111 Penn St. Balto., MD.  |   |   |  |   |   |   |                               |           |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |             | 23b. DATE  |                   | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION<br>CITY OR TOWN   |  | COUNTY  |   | STATE   |                               |           |
| Burial  |             | 11/13/1980   |                   | Oak Lawn  |   | Baltimore   |  |   |   | MD.   |                               |           |
| 24. FUNERAL DIRECTOR<br>NAME  |             |  |                   |   |   | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |   |   |                               |           |
| Duda-Ruck, Inc.<br>7922 Wise Ave. Dundalk, Md. 21222  |             |  |                   |   |   | NOV 12 1980   |  |  |   |   |                               |           |

MEDICAL CERTIFICATION

4201



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 27820

1 - FOR  
STATE  
REGISTRAR

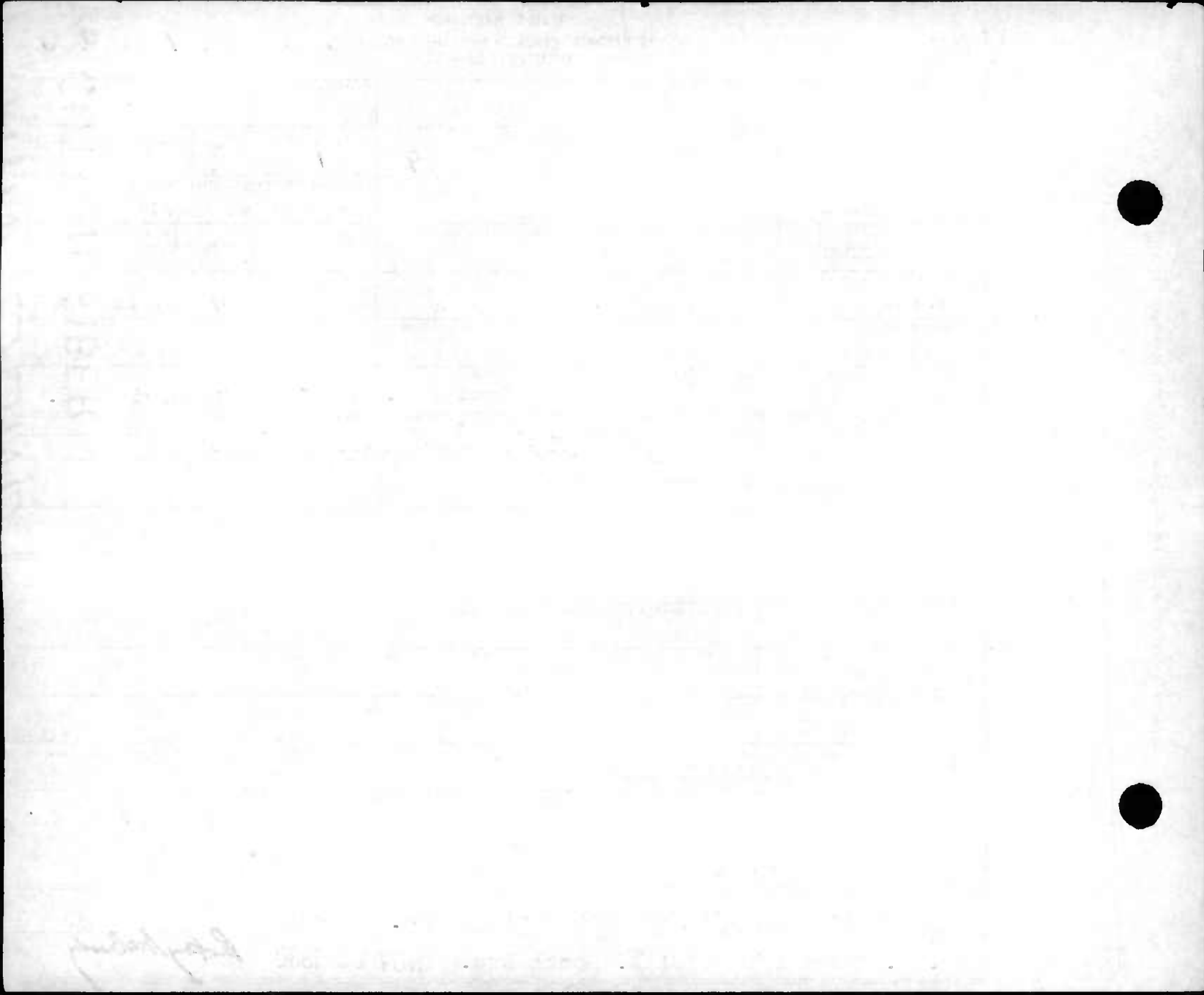
REG. NO.

|   |  |   |  |  |  |   |  |  |  |  |
|---|--|---|--|--|--|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>JUNIOUS M. BAKER  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Nov 10 80                       |  | 2b. HOUR<br>11:00 AM   |   |  |  |  |  |
| 3 SEX<br>MALE   |  | 4 RACE<br>NEGRO   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>2 22 29   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>51 YRS  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN  |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>N. CAROLINA   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD  |  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SBGH |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>BURNER                              |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a. STATE<br>MD.   |  |   | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>BALTIMORE   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>GEORGE BAKER   |  |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>DORA FREEMAN           |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>Yes |  |  |  |  |
| 16b. SOCIAL SECURITY NO.<br>237388665   |  |   | 17 INFORMANT ADDRESS<br>Louise G. Baker 717 Roundview Rd.              |  |  |   |  |  |  |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Metastatic liver disease (chemical)<br>1629<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c) LUNG CARCINOMA<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) |  |   |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                               |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/23/1980 to 11/10/1980, that (I) (we) last saw the deceased alive on 11/10/1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |   |  |  |  |  |
| 22b. SIGNATURE<br>Stavrou   |  |   | DEGREE   |  |  | 22c. DATE SIGNED<br>11/10/80  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>NICOS STAVROU M.D.   |  |   | 22e. ADDRESS<br>SBGH, HANOVER ST. 3001.<br>BALT. MD.                   |  |  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |   | 23b. DATE<br>11/14/80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowridge Cem.                         |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Laurel MD                              |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H 1101 E. North Ave.   |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 12 1980                                   |   | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 2 7 8 2 1

FOR  
1. STATE  
REGISTRAR

REG. NO.

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>LEMUEL LEE BAKER</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 13 1980</b>                              |  | 2b. HOUR<br><b>2:47 P.M.</b>   |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 19 07</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b>   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. AGNES HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Supervisor</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Acme Warehouse</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   |  |   | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Baltimore</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles Allen Baker</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Grace Colburn</b>                 |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>212-07-0286</b>  |   | 17. INFORMANT<br>ADDRESS <b>Balto., Md.</b><br><b>Laura V. Baker 319 Maryland Road 21229</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio Respiratory Arrest -</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ASCVD.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>11/13/80</b> , 19____, to <b>11/13/80</b> , 19____, that (I) (we) last saw the deceased alive on <b>11/13/80</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                 |  |   |   |  |  |
| 22b. SIGNATURE<br><b>NOOR M. MERCHANT M.D.</b>   |  | DEGREE  |   | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>NOOR M. MERCHANT M.D.</b>  |  | 22e. ADDRESS<br><b>900 S. CATON AVE. BALTIMORE, MD. 21229</b>   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   | 23b. DATE<br><b>11-17-80</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Crestlawn Gardens</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Marriottsville Howard co.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Hubbard Funeral Home, Inc.</b>  |  | ADDRESS<br><b>4107 Wilkens Ave.</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 14 1980</b>  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



BALTIMORE CITY

ST. ANNE'S HOSPITAL

BALTIMORE

JOHN A. CATY AND ELEANOR CATY

JOHN A. CATY AND ELEANOR CATY

1980



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

0000  
DHMH - 17  
(VR A15 ME (5))  
15M 2/80

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |                              |  |  |  |   |  |  |  | REG. NO. 27822   |  |                           |  |
|--|--|------------------------------|--|--|--|---|--|--|--|--|--|---------------------------|--|
| FOR REGISTRAR<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                              |  |  |  |   |  |  |  |  |  |                           |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>AKA: LaVern Lavern E. Ballistreri</b>  |  |                              |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> |  | 2b. HOUR <input type="checkbox"/>  |  |  |  |                           |  |
| 3. SEX <b>Female</b>   |  | 4. RACE <b>White</b>         |  | 5. DATE OF BIRTH <b>09 - 19-55</b>   |  | 6. AGE (IN YEARS) <b>25</b> YRS   |  | IF UNDER 1 YR. <input type="checkbox"/> MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN                 |  | 7c. DATE PRONOUNCED DEAD <b>11 14 19 80</b>                                      |  | 2d. HOUR <b>2:20</b> P.M. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>  |  |                              |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.                   |  |                           |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  |                              |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Union Memorial Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Cashier</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Food Store</b>                              |  |                           |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                              |  |  |  |   |  |  |  |  |  |                           |  |
| 13a. STATE <b>Maryland</b>   |  | 13b. COUNTY <b>Baltimore</b> |  | 13c. CITY OR TOWN <b>Perry Hall</b>  |  | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 13e. STREET ADDRESS <b>4 Duncroft Rd. Apt. 2T</b>  |  |  |  |                           |  |
| 14. FATHER'S NAME <b>Cyril Wagenfer</b>  |  |                              |  | 15. MOTHER'S MAIDEN NAME <b>Fern G. McLaughlin</b>   |  |   |  |  |  |  |  |                           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>   |  |                              |  | 16b. SOCIAL SECURITY NO. <b>219-66-5441</b>  |  |   |  | 17. INFORMANT <b>4 Duncroft Rd. Apt. 2T William J. Ballistreri</b>   |  |  |  |                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY: <b>Pneumonia</b><br>IMMEDIATE CAUSE (a) <b>4860</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |                              |  |  |  |   |  |  |  |  |  |                           |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):  |  |                              |  |  |  |   |  |  |  |  |  |                           |  |
| 19a. DATE OF OPERATION   |  |                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |  |  | 20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |                           |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                              |  | 21b. TIME OF INJURY <b>19</b> P.M.   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |  |  |  |  |                           |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |  |                              |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION <b>Overlea, Baltimore, Md.</b>  |  |  |  |  |  |                           |  |
| 22a. I certify that I took charge of the remains described above, held an <b>Autopsy</b> <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                              |  |  |  |   |  |  |  |  |  |                           |  |
| ACTUAL SIGNATURE <b>Margarita A. Korell</b>  |  |                              |  | TITLE (SPECIFY) <b>Assistant</b> MEDICAL EXAMINER  |  |   |  | DATE SIGNED <b>11-15-80</b>  |  |  |  |                           |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>   |  |                              |  | ADDRESS <b>111 Penn Street</b>   |  |   |  |  |  |  |  |                           |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  |                              |  | 23b. DATE <b>Nov. 18, 1980</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith</b>  |  | 23d. LOCATION <b>Overlea, Baltimore, Md.</b>   |  |  |  |                           |  |
| 24. FUNERAL DIRECTOR <b>ROBERT C. ALTENBURG</b>  |  |                              |  | 25a. DATE REC'D. BY REGISTRAR <b>NOV 17 1980</b>   |  |   |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>  |  |  |  |                           |  |
| 6009 Harford Rd., Balto., Md. 21214  |  |                              |  |  |  |   |  |  |  |  |  |                           |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 7 8 2 3

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |   |  |   |  |   |  |
|---|--|--|--|---|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>WALTER F. BANASZEWSKI</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 1 80</b>                  |   |   | 2b. HOUR<br><b>63<sup>0</sup> PM</b>   |   |  |   |  |
| 3. SEX<br><b>M</b>  |  | 4. RACE<br><b>W</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 3 10</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS.                                    |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                    |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore City Hospitals</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>laborer</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Bethel-Steel</b>   |   |  |
| 13a. STATE<br><b>Maryland</b>   |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>                                       |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1138 Dundalk Avenue</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Frank Banaszewski</b>  |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Catherine ?</b>         |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>213 07 0352</b>                         |   | 17. INFORMANT<br>ADDRESS<br><b>Florence Banaszewski 1138 Dundalk Avenue</b> |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CAROTID PULMONARY ARREST</b><br><b>5130</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>PNEUMONIA</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>LUNG ABSCESS</b> |  |  |  |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):   |  |  |  |   |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>OCT 1</b> 19 <b>80</b> , to <b>NOV 1</b> 19 <b>80</b> , that (I) (we) lost<br>saw the deceased alive on <b>NOV 1</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (I) (we) (did) (did not) view the body after death.                                    |  |  |  |   |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Peter Paul Stamas MD</b>   |  |  |  |   |   | DEGREE<br><b>MD</b>  |   | 22c. DATE SIGNED<br><b>11-1-80</b>   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PETER PAUL STAMAS MD</b>  |  |  |  |   |   | 22e. ADDRESS<br><b>BCH</b>   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>11/5/80</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Cross</b>                     |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md</b>  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Walter Dabrowski</b>   |  |  |  |   |   | ADDRESS<br><b>1005 Dundalk Avenue</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 10 1980</b>  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified for an autopsy.

11/2/50 Holy Cross  
1005 North Main Street  
St. Louis, Mo.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS ANTICIPATED, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                  |   |  |  |   |  |   |  |                       | REG. NO. 0 27824   |  |
|---|------------------|---|--|--|---|--|---|--|-----------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>John B. Banks   |                  |   |  |  |   |  |   |  |                       | 2a. DATE KNOWN OF DEATH ESTI-MATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br>11 3 1980 |  |
| 3. SEX<br>Male  | 4. RACE<br>Black | 5. DATE OF BIRTH MONTH DAY YEAR<br>6 24 04 76 YRS.  |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.         | IF UNDER 1 YR.  | IF UNDER 24 HRS.   | 2c. DATE PRONOUNCED DEAD<br>11 3 1980                       |  | 2d. HOUR<br>9:23 P.M. |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Va.  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD. |  |                       |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2600 Blk. Llyewelyn Avenue |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                |   | 12b. KIND OF BUSINESS OR INDUSTRY                  |                       |  |  |
| 13a. STATE<br>MD  |                  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>BALTO                                     |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS                                |                       |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>John Banks   |                  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Martha J. Mags   |   |  |   |  |                       |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br>yes   |                  | (IF YES, GIVE WAR OR DATES)<br>WWII   |  | 16b. SOCIAL SECURITY NO.<br>225-16-5160                        |   | 17. INFORMANT ADDRESS<br>Rachel R. Banks 2506 Joseph Ave.                                    |   |  |                       |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hypertensive cardiovascular disease</u><br>4029<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF  |                  |   |  |  |   |  |   |  |                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |                  |   |  |  |   |  |   |  |                       |  |  |
| 19a. DATE OF OPERATION  |                  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?              |   |  |   |  |                       | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19        |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                |   |  |                       |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |                  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)    |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |  |                       |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                  |   |  |  |   |  |   |  |                       |  |  |
| ACTUAL SIGNATURE<br><i>Thomas D. Smith</i>  |                  |   |  | TITLE (SPECIFY)<br>M.D. Deputy Chief                           |   |  |   | DATE SIGNED<br>11/4/80                             |                       |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Thomas D. Smith, M.D.  |                  |   |  | ADDRESS<br>111 Penn St. Balto., MD.                            |   |  |   |  |                       |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |                  | 23b. DATE<br>11/11/80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>1st Baptist Ch. Cemetery |   |  |   | 23d. LOCATION<br>Topping Inc. U.A.                 |                       |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Chas. H. Powell  |                  | ADDRESS<br>319 N. Schroeder St.   |  | 25a. DATE REC'D. BY REGIS. CLK.<br>NOV 12 1980                 |   |  |   | 25b. REGISTRAR'S SIGNATURE<br><i>John H. Kelly</i> |                       |  |  |

Handwritten text, mostly illegible due to fading. Some words like "and" and "the" are visible.

Handwritten text at the bottom of the page, including the word "and" and other faint markings.



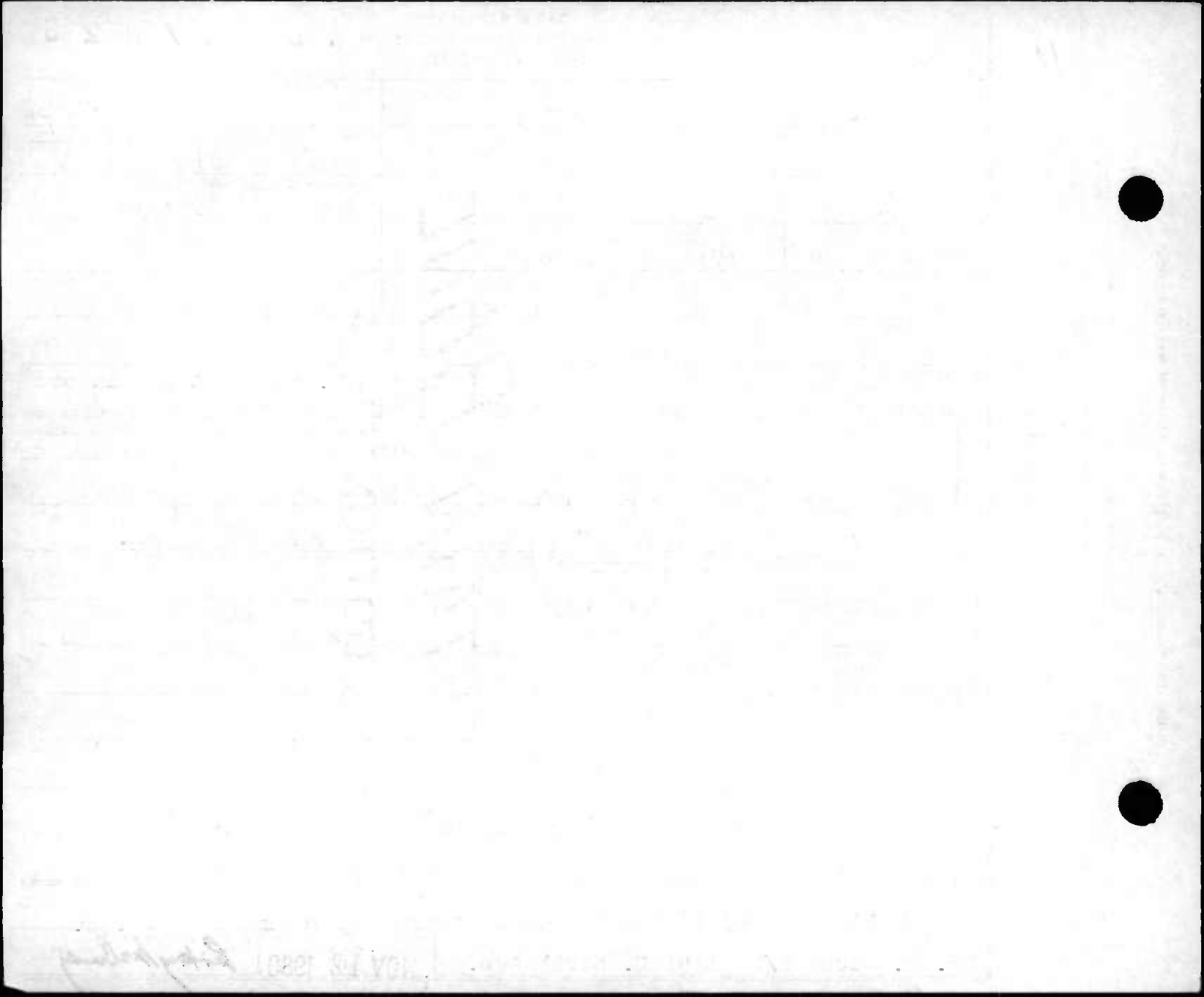
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |   |  |   |  |  |  | 8 0 2 7 8 2 5 |  |
|---|--|--|--|---|--|---|--|--|--|---------------|--|
| 1 - FOR STATE REGISTRAR   |  |  |  |   |  |   |  |  |  | REG. NO.      |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Benjamin Barnes</b>  |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 10 80</b>  |  | 2b. HOUR<br><b>8:20 PM</b>   |  |               |  |
| 3. SEX<br><b>M</b>  |  | 4. RACE<br><b>B</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 14 29</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>51</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Florida</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balt. City / Kessler MD.</b>                         |  |  |  |               |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore Md</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Mercy Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |               |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>642 Stanford Rd</b>  |  |               |  |
| 13a. STATE<br><b>md</b>   |  | 13b. COUNTY<br><b>Balto City</b>   |  | 13c. CITY OR TOWN   |  |   |  |  |  |               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Elijah Barnes</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Hattie Edwards</b>  |  |   |  |  |  |               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>unknown</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>263-34-2839</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Hattie M. Barnes 642 Stanford<br/>Mercy Hosp Records.</b>  |  |   |  |  |  |               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>cardiopulmonary arrest</b><br><b>1991</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Hypercalcemia, possible sepsis.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>metastatic squamous cell Ca.</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>moments.</b><br><b>4 months</b><br><b>15 months.</b> |  |  |  |   |  |   |  |  |  |               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |  |  |   |  |   |  |  |  |               |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/15</b> 19 <b>80</b> , to <b>11/10</b> 19 <b>80</b> , that (I) (we) lost<br>saw the deceased alive on <b>11/10</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |  |  |               |  |
| 22b. SIGNATURE<br><b>Kenneth B Kessler, MD</b>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br><b>11/10/80</b>  |  |               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Kenneth B Kessler, MD</b>   |  |  |  | 22e. ADDRESS<br><b>Mercy Hospital, Balto. Md</b>  |  |   |  |  |  |               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>11/15/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Church Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Mariana Fla.</b>                               |  |  |  |               |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H 1101 E. North Ave.</b>  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 12 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Patricia McBrady</b>  |  |               |  |



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

2 7 8 2 6

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|  |   |  |  |  |                                   |
|--|---|--|--|--|-----------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>SYLVIA BELL BARNES  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>NOV. 14 '80                            |  | 2b. HOUR<br>10:15 PM              |
| 3. SEX<br>FEMALE   | 4. RACE<br>NEGRO  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>08 29 33   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>47 YRS.                                 |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD  | 7b. CITIZEN OF WHAT COUNTRY?<br>US  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE MD                       |                                   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>S.B.G.H. |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>L.P.N. |  | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md   |   | 13b. COUNTY<br>AA  |  | 13c. CITY OR TOWN<br>Earleigh Hgts   |                                   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Brown   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elizabeth Brown   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No |                                   |
| 16b. SOCIAL SECURITY NO.<br>218-28-8324  |   | 17. INFORMANT<br>GLADYS J. CARP  |  | ADDRESS<br>SAMPSON 13E   |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u><br>1830 DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>OVARIAN CARCINOMA</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <u>WIDE-SPREAD METASTASIS</u> |   |  |  |  |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |  |  |  |                                   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)               |  |  |                                   |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)   |  |  |                                   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                          |                                   |
| 22a. I certify that (this hospital) attended the deceased from <u>Sept 5</u> 19 <u>1980</u> to <u>NOV. 14</u> 19 <u>80</u> , that (we) lost saw the deceased alive on <u>NOV 14</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.              |   |  |  |  |                                   |
| 22b. SIGNATURE<br>Jeffrey H. Dysart, M.D.  |   |  |  | 22c. DATE SIGNED<br>14 NOV. 1980   |                                   |
| 22d. PHYSICIAN'S NAME (THREE PRINTS)<br>JEFFREY H. DYSART  |   |  |  | 22e. ADDRESS<br>S.B.G.H.   |                                   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |   | 23b. DATE<br>11-22-80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>SILAS                                |                                   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Earleigh Hgts AA Md  |   | 24. FUNERAL DIRECTOR<br>NAME<br>C. E. Hicks  |  |  |                                   |
| 25a. DATE REC'D. BY REGISTRAR<br>NOV 24 1980   |   | 25b. REGISTRAR'S SIGNATURE<br>R. J. [Signature]  |  |  |                                   |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP \_\_\_\_\_

OFFICE OF THE  
DIRECTOR OF THE  
BUREAU OF THE  
CENSUS



*[Faint, illegible handwritten text covering the majority of the page]*

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 27827

REG. NO.

1- STATE  
REGISTRAR

|  |  |   |  |   |                                |  |
|--|--|---|--|---|--------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>BERRACK, Bertram L. BARRACK   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>11/18/80 |   | 2b. HOUR<br>8 <sup>45</sup> AM |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Black  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>May 5 1897   |                                |  |
| 6. AGE (IN YEARS (LAST BIRTHDAY))<br>83 YRS.   |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VA   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |                                |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |  |   |                                |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore City Hospital |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>MD.                            |                                |  |
| 12b. KIND OF BUSINESS OR INDUSTRY  |  | 13a. STATE<br>Md.   |  |   |                                |  |
| 13b. COUNTY<br>Balt.   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                |  |
| 13e. STREET ADDRESS<br>2420 Woodbrook Ave  |  | 14. FATHER'S NAME FIRST MIDDLE LAST<br>Richard Barrack  |  |   |                                |  |
| 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Gertrude Warrington  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes  |  |   |                                |  |
| 16b. SOCIAL SECURITY NO.<br>217095742  |  | 17. INFORMANT ADDRESS<br>Eva Wilson 2420 Woodbrook Ave.   |  |   |                                |  |

|   |  |  |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiac arrest<br>(b) 65-530 TBSA burn<br>(c) DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>10 min<br>7 week |
|---|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                    |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 11 12 1980                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br>Pt burned in nursing home |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>Nursing Home |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br>2420 Woodbrook Ave Baltimore Md                           |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/18/80 to 11/18/80, that (I) (we) last saw the deceased alive on 11/18/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Waldo Floyd M.D.   |  |   |  | DEGREE<br>M.D.  |  | 22c. DATE SIGNED<br>11/18/80   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Waldo Floyd M.D.  |  |   |  | 22e. ADDRESS<br>Baltimore City Hospital   |  |  |  |

|   |  |                       |  |   |  |   |  |
|---|--|-----------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial |  | 23b. DATE<br>11/21/80 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Crownsville VA Cen. |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Crownsville MD |  |
| 24. FUNERAL DIRECTOR NAME<br>Wm. C. March F/H       |  |                       |  | ADDRESS<br>1101 E. North Ave.                             |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 21 1980              |  |
| 25b. REGISTRAR'S SIGNATURE                          |  |                       |  |   |  |   |  |

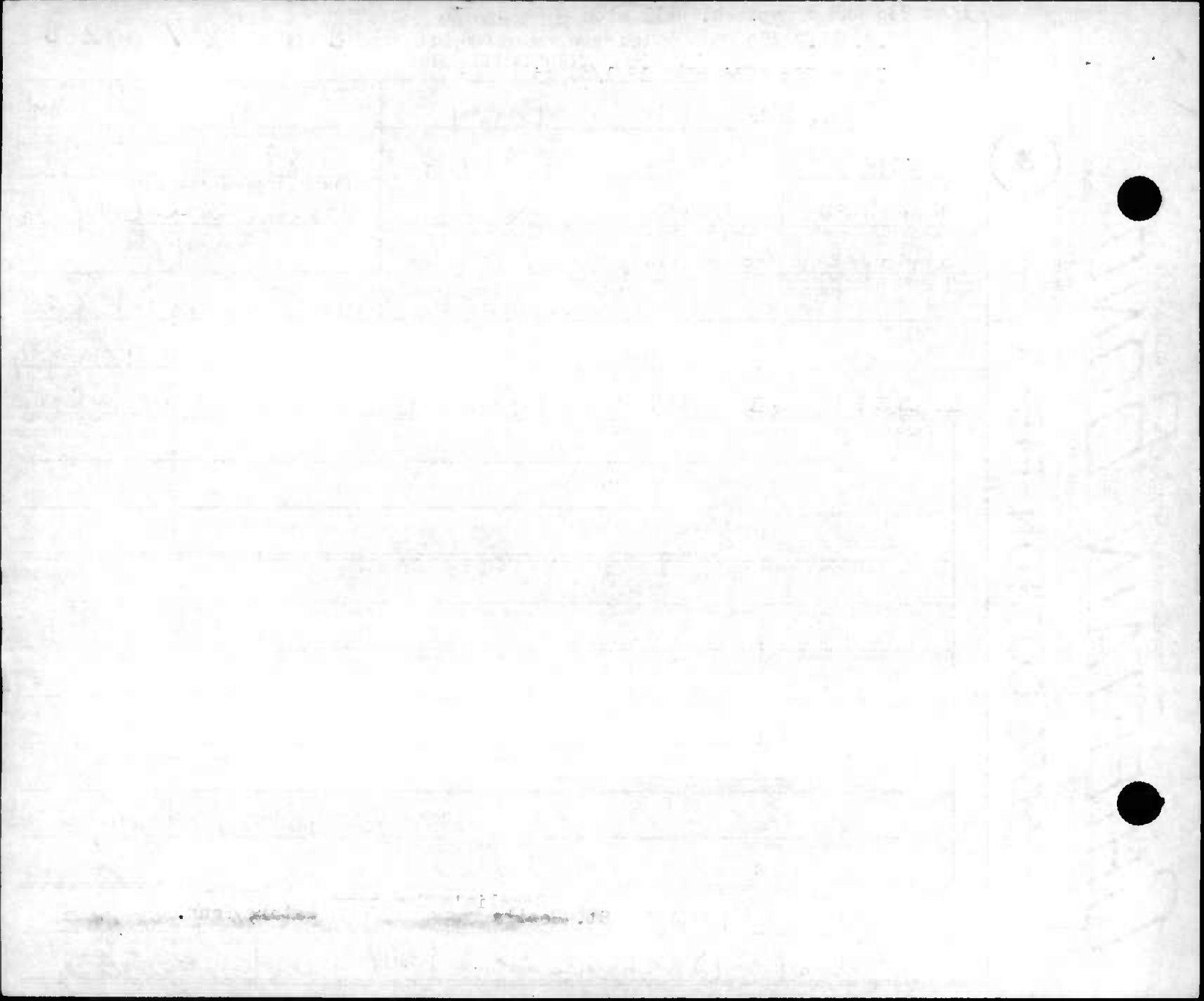


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| Item 23c and d Per. Ph. call with  |  | STATE OF MARYLAND   |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  | 80 27828   |  |
|--|--|---|--|--|--|--|--|
| 1. STATE REGISTRAR   |  | F.H. 11/20/80 GB  |  | CERTIFICATE OF DEATH   |  | REG. NO.   |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST MIDDLE LAST   |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  | 2b. HOUR   |  |
| Charles M Barry  |  |   |  | 11 15 80   |  | 2:10 AM  |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                  |  |
| Male   |  | white   |  | 3 17 91  |  | 89   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH             |  |
| MARYLAND   |  | USA   |  |  |  | Baltimore City MD.                               |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                                 |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                |  |
| Baltimore  |  | Good Samaritan Hospital   |  |  |  |  |  |
| 13a. STATE   |  | 13b. CITY OR TOWN   |  | 13c. INSIDE CITY LIMITS?   |  | 13d. STREET ADDRESS                              |  |
| Md.  |  | Baltimore   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 9003 Perring Prk Rd.                             |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.                         |  |
| James Barry  |  | MGT. Kennedy  |  | Unknown  |  | 189-05-6907                                      |  |
| 17. INFORMANT ADDRESS  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) (b) (c)   |  | 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED |  |
| Marie Overtoom 9003 Perring Park Rd.   |  | 1629 TERMINAL METASTATIC LUNG CA  |  | N/A  |  | N/A  |  |
|  |  | DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |
|  |  | DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |
|  |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |  |  |  |  |
| 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?  |  | 21a. INJURY OCCURRED   |  | 21b. PLACE OF INJURY                             |  |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  | 21d. LOCATION                                    |  |
|  |  |   |  |  |  | CITY OR TOWN COUNTY STATE                        |  |
|  |  |   |  |  |  | BALTIMORE MD.                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from   |  | 22b. SIGNATURE  |  | 22c. DATE SIGNED   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)            |  |
| 11/13 1980, to 11/15 1980, that (I) (we) lost  |  | L. Cueto  |  | 11/15/80   |  | LEDUVINA L. CUETO                                |  |
| saw the deceased alive on 11/15 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  | 22e. ADDRESS                                     |  |
|  |  |   |  |  |  | 8422 AVERY ROAD, BALT. MARYLAND                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION                                    |  |
| Burial   |  | 11/17/80  |  | St. Cecilia's Cemetery   |  | Exeter, Penn.                                    |  |
| 24. FUNERAL DIRECTOR NAME  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |  | 25c. REGISTRAR'S SIGNATURE                       |  |
| J. G. Gwalt  |  | NOV 19 1980   |  | D. H. Gwalt  |  | D. H. Gwalt                                      |  |





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 27829

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JOSEPH BARSON</b>   |  |  | 2a. DATE OF DEATH<br>MONTH <b>NOV</b> DAY <b>1</b> YEAR <b>1980</b>  |  | 2b. HOUR<br><b>9:55 P</b>  |
| 3. SEX<br><b>male</b>  | 4. RACE<br><b>white</b>  | 5. DATE OF BIRTH<br>MONTH <b>3</b> DAY <b>25</b> YEAR <b>95</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>                                 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Romania</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. <b>BALTIMORE CITY</b> OR COUNTY OF DEATH  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Pleasant manor, W/H.</b> |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Unknown</b>                              |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD.</b>  | 13b. COUNTY<br><b>Balto.</b>   | 13c. CITY OR TOWN<br><b>Balto.</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   | 13e. STREET ADDRESS<br><b>4615 Park Heights Ave</b>  |  |
| 14. FATHER'S NAME<br>FIRST <b>ASHLIE</b> MIDDLE <b>BARSON</b> LAST <b>BARSON</b>   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Anna</b> MIDDLE <b>Decu</b> LAST <b>Decu</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>   |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>213-07-455</b>  |  | 17. INFORMANT<br><b>REGAN SIBRIA</b> ADDRESS <b>11123 OLD CARRIAGE Rd.</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br><b>1539</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma, colon</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>perforated, metastatic</b> |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 Day</b><br><b>11 Months</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |
| <b>arteriosclerotic Heart Disease</b>  |  |  |  |  |  |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 9</b> , 19 <b>80</b> , to <b>Nov 1</b> , 19 <b>80</b> , that (I) (we) lost the deceased alive on <b>Nov 1</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Manuel Levin</b>  |  | DEGREE<br><b>MD</b>  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11/1/80</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MANUEL LEVIN MD</b>  |  | 22e. ADDRESS<br><b>6101 Park Heights Ave BALTO MD 21215</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>  | 23b. DATE<br><b>NOV 3-1980</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SECURITY PROCESS</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. MD</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Connelly FH</b> ADDRESS <b>300 Trace Ave</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 6 1980</b>   |  |  |  |
|  |  | REGISTRAR'S SIGNATURE<br><b>Henry McBratney</b>  |  |  |  |

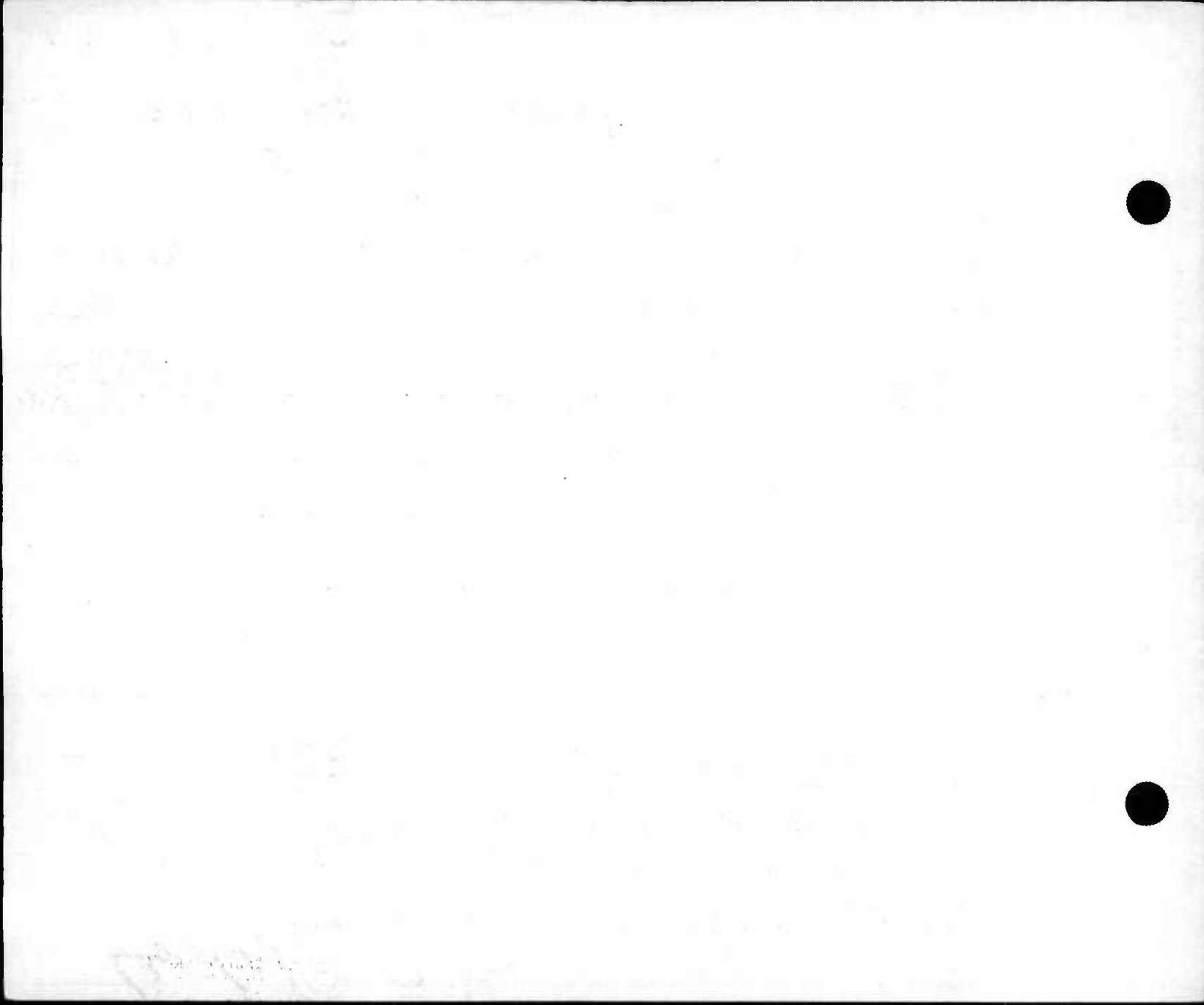
TO HOSPITAL OR ATTENDING PHYSICIAN. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

BP

DHHM-16 20M  
(VRA 15, 4) 7/78



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 7 8 3 0

REG. NO.

FOR  
1. STATE  
REGISTRAR

|   |  |  |   |  |  |   |  |  |
|---|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Lawrence                             |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 15 80         |  |  | 2b. HOUR<br>M   |  |  |
| 3. SEX<br>male  |  |  | 4. RACE<br>Black  |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 13 21   |  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>59 YRS.                                  |  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS                       |  |  | 7. IF UNDER 24 HRS<br>HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>U.S.A. ✓                       |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City                      |  |  | 10. CITY OR TOWN OF DEATH<br>Baltimore                  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>4613 Pen Lucy Rd.                              |  |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                       |  |  | 13a. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |
| 13b. STREET ADDRESS<br>4613 Pen Lucy Rd.                                    |  |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Lawrence Bass |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Carrie Aiken   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes |  |  | 16b. SOCIAL SECURITY NO<br>WWII                         |  |  | 17. INFORMANT<br>Philip Bass  |  |  |
| 18. ADDRESS<br>4613 Pen Lucy Rd.  |  |  | 19. DATE OF OPERATION                                   |  |  | 20. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |

19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1: DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

4100  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Vent. Pulmonary

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

10 min

Ac Myocardial Ischemia

1 NR

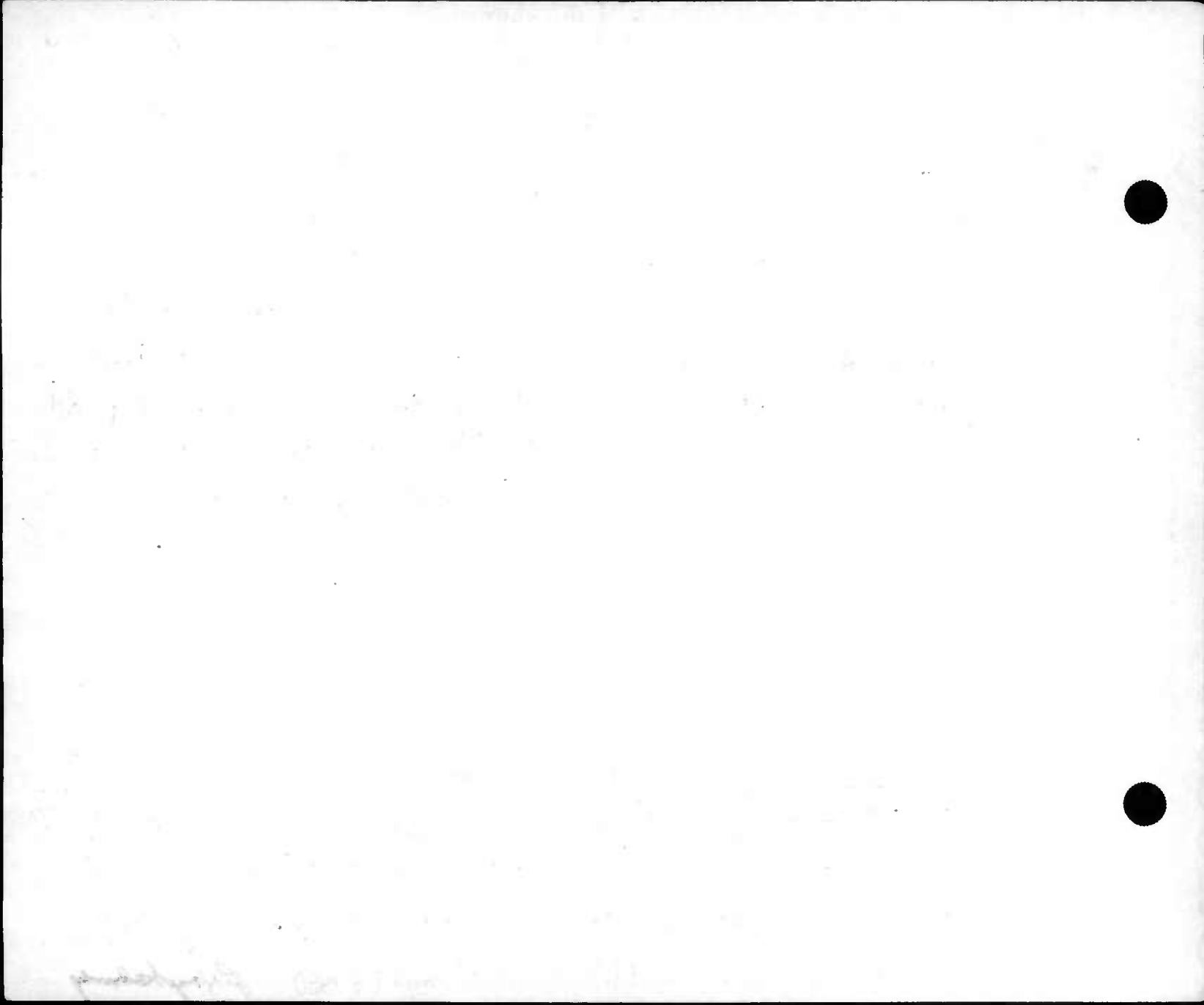
ASCVD

±15 yrs

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

|  |  |  |  |  |  |   |  |  |  |  |  |
|--|--|--|--|--|--|---|--|--|--|--|--|
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)       |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  | 21g. I certify that (I) (this hospital) attended the deceased from<br>19 74 to 11/15 80, that (I) saw the deceased alive on 11/12 80, and that in my opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. |  |  |
| 22a. SIGNATURE<br>Raymond E. Caplan  |  |  | 22b. DEGREE<br>M.D.  |  |  | 22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  | 22d. DATE SIGNED<br>11/17/80   |  |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br>RAYMOND E. CAPLAN   |  |  | 22f. ADDRESS<br>2435 W. BELVEDERE AVE.                                 |  |  |   |  |  |  |  |  |

|  |  |  |                                   |  |  |  |  |  |  |  |  |
|--|--|--|-----------------------------------|--|--|--|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial |  |  | 23b. DATE<br>11/20/80             |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>King Mem Pk. |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Randallstown Md. |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>James A. Morton & Sons |  |  | 24b. ADDRESS<br>17016 Laurens St. |  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 19 1980       |  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]                      |  |  |



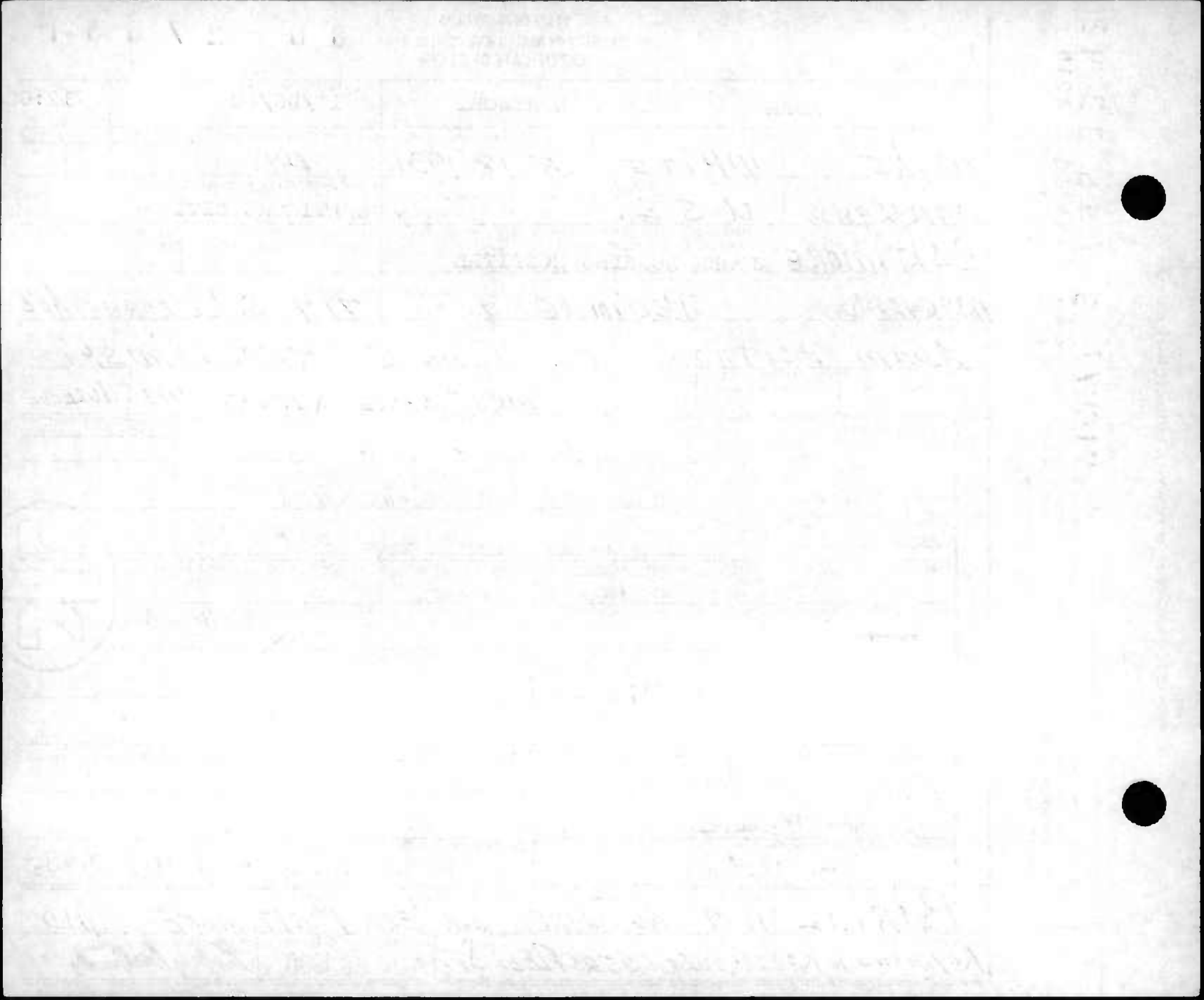
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

80 27831

1. FOR  
STATE  
REGISTRAR

|   |  |   |   |   |                        |   |  |   |  |   |  |
|---|--|---|---|---|------------------------|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>ADAM BARTECKI   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11/05/80 |   | 2b. HOUR<br>12:08<br>M |   |  |   |  |   |  |
| 3. SEX<br>male  |  | 4. RACE<br>WHITE  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 18 1931   |                        | 6. AGE [IN YEARS LAST BIRTHDAY]<br>49 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN.                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                        | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>JOHNS HOPKINS HOSPITAL |   |   |                        | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |
| 13a. STATE<br>MARYLAND  |  | 13b. COUNTY   |   | 13c. CITY OR TOWN<br>BALTIMORE  |                        | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>717 S. LUZERNE AVE   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>ADAM BARTECKI SR  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>JENNIE KRASNDIMSKI   |                        |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT<br>ADDRESS<br>MRS JENNIE RUPERT 717 S. LUZERNE  |                        |   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Bran death &amp; flatline EEG</u><br><u>4273</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Massive C CVA &amp; mass effect</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>massive cerebral emboli 2° to c. fibrillation</u>          |  |   |   |   |                        |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><u>myocardial infarction</u>  |  |   |   |   |                        |   |  |   |  |   |  |
| 19a. DATE OF OPERATION<br><u>NONE</u>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |                        | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR AM MONTH DAY YEAR<br><u>NONE</u> 19 <u>80</u>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                        |   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                        |   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/05</u> , 19 <u>80</u> , to <u>11/05</u> , 19 <u>80</u> , that (I) (we) lost<br>saw the deceased alive on <u>11/05</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |   |   |                        |   |  |   |  |   |  |
| 22b. SIGNATURE<br><u>John Mannisi</u>   |  |   |   | DEGREE<br><u>MD</u>   |                        |   |  | 22c. DATE SIGNED  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>John Mannisi</u>  |  |   |   | 22e. ADDRESS<br><u>601 N Broadway Balt. MD 21205</u>  |                        |   |  |   |  |   |  |
| 23a. BURIAL CREMATION, REMOVAL<br><u>BURIAL</u>   |  | 23b. DATE<br><u>11-7-1980</u>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>SACRED HEART CEM</u>   |                        | 23d. LOCATION<br>CITY OR TOWN COUNTY<br><u>BALTIMORE MD</u>                                     |  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Raymond L. Kaczorowski</u>   |  |   |   | ADDRESS<br><u>2525 FLEET ST.</u>  |                        | 25a. DATE REC'D. BY REGISTRAR<br><u>NOV 6 1980</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer's death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the death.

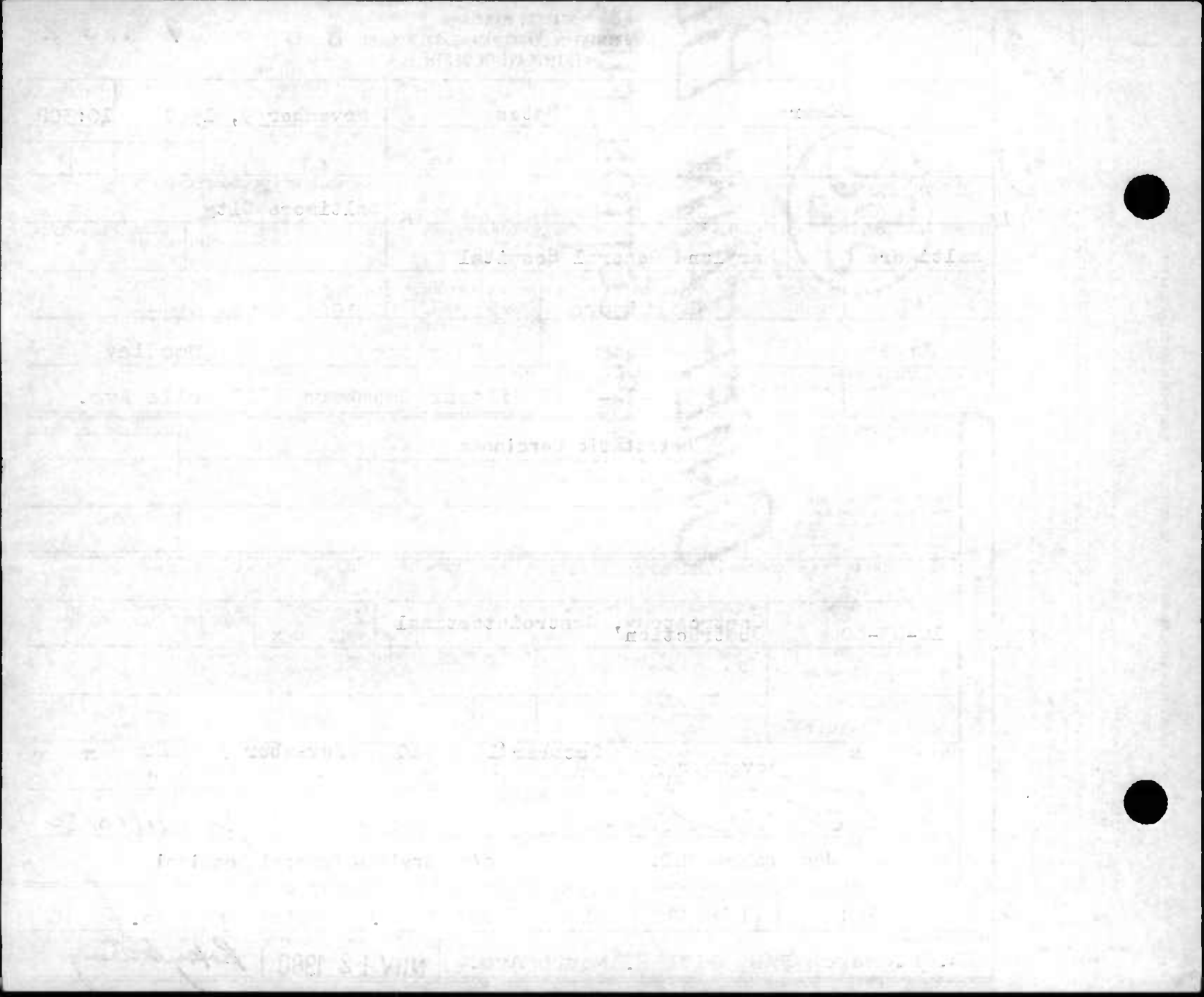
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 7 8 3 2

REG. NO.

1 - FOR  
STATE  
REGISTRAR

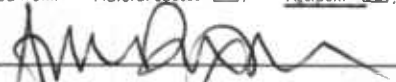

|  |  |  |   |   |  |  |  |  |  |
|--|--|--|---|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Edward Bates  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 9, 1980 |   |  | 2b. HOUR<br>10:30 PM   |  |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Negro   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2 15 17   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>63 YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>GA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Maryland General Hospital |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |   |   |  |  |  |  |  |
| 13a. STATE<br>MD   |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br>1701 Entaw Place  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>James Bates  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Charlene Woodley   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>258-22-1333   |   | 17. INFORMANT ADDRESS<br>Silemar Chambers 5527 Belle Ave.   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Metastatic Carcinoma<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF  |  |  |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |  |   |   |  |  |  |  |  |
| 19a. DATE OF OPERATION<br>10-23-80   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Gastrostomy, Gastrointestinal Obstruction  |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>October 9</u> , 19 <u>80</u> , to <u>November 9</u> , 19 <u>80</u> , that <input checked="" type="checkbox"/> (we) lost <u>see the deceased alive on November 9</u> , 19 <u>80</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated <u>above</u> (we) (did) (did not) view the body after death. |  |  |   |   |  |  |  |  |  |
| 27b. SIGNATURE<br>  |  |  |   |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>11/10/80   |  |
| 27d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Jon Graham, M.D.  |  |  |   | 27e. ADDRESS<br>c/o Maryland General Hospital   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>11/14/80  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>King Memorial Pk.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Co. MD   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H 1101 E. North Ave.  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 12 1980  |  | 25b. REGISTRAR'S SIGNATURE<br>                                  |  |  |  |





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                         |  |   |  |   |  |  |  | REG. NO. 0 27833  |  |
|---|--|-------------------------|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>WILLIAM C. BATES</b>   |  |                         |  |   |  |   |  |  |  | 2b. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>11 27 1980</b> |  |
| 3. SEX<br><b>male</b>   |  | 4. RACE<br><b>negro</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>Aug. 5, 1931</b>  |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) <b>49</b> YRS.                     |  | IF UNDER 1 YR.<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balto., Md.</b>   |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2422 W. Cold Spring Lane</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE <b>Md.</b>   |  |                         |  |   |  |   |  |  |  | 13b. COUNTY   |  |
| 13c. CITY OR TOWN<br><b>Balto.</b>  |  |                         |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>2422 W. Coldspring la.</b>                    |  |  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William C. Bates, Sr</b>   |  |                         |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Beatrice Bates</b>  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, GIVE WAR OR DATES)<br><b>yes Army</b>   |  |                         |  | 16b. SOCIAL SECURITY NO.<br><b>213-28-8970</b>  |  | 17. INFORMANT ADDRESS<br><b>Mrs. Helen Bates 2422 W. Coldspring La.</b> |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>8809</b> IMMEDIATE CAUSE (a) <b>Cranio-cerebral trauma complicating alcoholism</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |                         |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |                         |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |  |  |   |  |
| 20a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                         |  | 20b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>? P.M. 11-27- 1980</b>  |  |   |  | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Apparently fell down steps.</b>                              |  |   |  |
| 21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK   |  |                         |  | 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>home</b>  |  |   |  | 21c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>2422 W. Cold Spring Lane, Balto. Md.</b>   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on <u>Autopsy</u> <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                         |  |   |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE<br>   |  |                         |  | TITLE (SPECIFY)<br><b>Assistant</b>   |  |   |  | DATE SIGNED <b>11-28-80</b>  |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Ann M. Dixon, M.D.</b>  |  |                         |  | ADDRESS<br><b>111 Penn St.</b>  |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |                         |  | 23b. DATE<br><b>12/2/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Memorial Pk.</b>          |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b>                                       |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Leroy O. Dyett 4600 Liberty Heights Ave.</b>   |  |                         |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 1 1980</b>                      |  | 25b. REGISTRAR'S SIGNATURE<br>                              |  |   |  |



... ..

... ..

... ..

... ..

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |   |   |   |  |  |  |  | 80   | 27  | 8   | 3                                 | 4 |
|--|--|--|---|---|---|--|--|--|--|--|---|---|-----------------------------------|---|
| 1 - FOR STATE REGISTRAR  |  |  |   |   |   |  |  |  |  | REG. NO.   |   |   |                                   |   |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>Marie E. BAUBLITZ</b>   |  |  |   |   | 2a. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>30</b> YEAR <b>80</b>   |  |  |  |  | 2b. HOUR<br><b>11:15 A.M.</b>  |   |   |                                   |   |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>white</b>  |   | 5. DATE OF BIRTH<br>MONTH <b>10</b> DAY <b>03</b> YEAR <b>1921</b>      |   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>59</b> |  |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>   |   | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b>  |                                   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Carroll Co MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>UNION MEMORIAL-BALTIMORE CITY MD.</b>     |  |  |   |   |                                   |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b> |   |   |   |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>  |   |   | 12b. KIND OF BUSINESS OR INDUSTRY |   |
| 13a. STATE<br><b>Md.</b>   |  |  |   |   | 13b. COUNTY<br><b>Balto.</b>  |  | 13c. CITY OR TOWN<br><b>Owings Mills</b>     |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>12127 Park Heights Ave.</b> |   |                                   |   |
| 14. FATHER'S NAME<br>FIRST <b>George</b> MIDDLE <b>Springman</b> LAST <b>Springman</b>   |  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Hattie</b> MIDDLE <b>Zurin</b> LAST <b>Zurin</b>   |  |  |  |  |  |   |   |                                   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>213-18-7473</b>   |   | 17. INFORMANT ADDRESS<br><b>Mr. Jesse W. Baublitz Owings Mills, Md.</b> |   |  |  |  |  |  |   |   |                                   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cancer of Ovary</b> <b>Acute Pulmonary Edema</b> <b>1d</b><br><b>1830</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Acute renal failure</b> <b>pd</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cancer of Ovary</b> <b>months.</b> |  |  |   |   |   |  |  |  |  |  |   |   |                                   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |   |   |   |  |  |  |  |  |   |   |                                   |   |
| 19a. DATE OF OPERATION<br><b>10/31/80</b>  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>abdominal mass</b> |   |   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |   |                                   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>         |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |  |   |   |                                   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)    |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |  |   |   |                                   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/24, 1980</b> to <b>11/30, 1980</b> , that (I) (we) lost<br>saw the deceased alive on <b>11/10, 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |  |   |   |   |  |  |  |  |  |   |   |                                   |   |
| 22b. SIGNATURE<br><b>Alan Kimmel</b> DEGREE <b>MD</b>  |  |  |   |   |   |  |  |  |  | 22c. DATE SIGNED<br><b>11/30/80</b>  |   |   |                                   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Alan Kimmel</b>  |  |  |   |   |   |  |  |  |  | 22e. ADDRESS<br><b>Union Memorial Hospital</b>   |   |   |                                   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(CHECK ONE)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>Dec. 3, 80</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge Cemetery</b>   |  |  | 23d. LOCATION<br><b>Pikesville Md.</b> COUNTY STATE                                  |  |  |   |   |                                   |   |
| 24. FUNERAL DIRECTOR<br>NAME <b>Eline Funeral Home</b> ADDRESS <b>Reisterstown, Md. 21136</b>  |  |  |   |   |   |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 2 1980</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Ruby McBrady</b> |                                   |   |

1970

1990

## SYNOPSIS

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

496

0

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 7 8 3 5

REG. NO.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Olivia Elizabeth Bauer</b><br><b>BAUER, ELIZABETH</b>   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Nov 17 80</b>   |  | 2b. HOUR<br>5 <sup>35</sup> AM   |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>March 20 1905</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Baltimore, Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Assembler</b>                                       |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>-</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Harry S. Appleby</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Carrie Hepting</b>  |  | 17. INFORMANT<br><b>James Ave. 8504</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE YEAR OR DATES)<br><b>220 30 6265</b>  |  | 17. INFORMANT<br><b>Murhl Bauer, Son Baltimore, Md. 21234</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio-pulmonary arrest</b><br>2754<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Hypocalcemia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>unknown</b> |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>11/17/80</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Cardio-pulmonary arrest</b>  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from <b>Oct 15</b> , 19 <b>80</b> , to <b>Nov 17</b> , 19 <b>80</b> , that (we) lost saw the deceased alive on <b>Nov 16</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                               |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>N. Joseph Gagliardi MD</b>  |  |   |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>11/17/80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>N. Joseph GAGLIARDI</b>  |  |   |  | 22e. ADDRESS<br><b>Union Memorial Hospital, Balt, Md.</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(S) <b>Burial</b>   |  | 23b. DATE<br><b>11/20/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holly Hill Memorial Gardens</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co., Md.</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>Bruzdzinski Funeral Home PA 1407 Old Eastern Ave</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 19 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>D. J. McNeely</b>   |  |



RECEIVED

WHITE

RECEIVED

BALTIMORE CITY

UNION LABORERS HOSPITAL

BALTIMORE

NOV 2 1980

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |   |  |  |  |  |   |   |
|--|--|---|---|--|--|--|--|---|---|
| 1. DECEASED-NAME (Type or print) First Alice Middle Lillian Last Baugher   |  |   | 2a. DATE OF DEATH Month 11 Day 15 Year 1980             |  |  | 2b. HOUR 10:05   |  |   |   |
| 3. SEX Female  |  | 4. RACE Caucasian   |   | 5. DATE OF BIRTH 10/14/1884  |  | 6. AGE (In years last birthday) 96 YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |   |
| 7a. BIRTHPLACE (State or foreign country) West Virginia  |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH Baltimore City Md.  |  |   |   |
| 10. CITY OR TOWN OF DEATH Baltimore  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) US Public Health |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) RETIRED   |  | 12b. KIND OF BUSINESS OR INDUSTRY HOUSE WORK.  |  |   |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland   |  | 13b. COUNTY Baltimore   |   | 13c. CITY OR TOWN Baltimore  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER 3132 Remington Ave. #21211.      |   |
| 14. FATHER'S NAME First Jim Middle Lough Last  |  |   | 15. MOTHER'S MAIDEN NAME First Mary Middle simmons Last |  |  |  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no  |  | 16b. SOCIAL SECURITY NO. 220-10-8682  |   | 17. INFORMANT Address Records US Public Health   |  |  |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 1539 Cardiac arrest<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Severe hypovolemia<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Large Bowel Obstruction-Etio. Unknown<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>suspected carcinoma colon with lung mets. : resuscitation pneumothorax |  |   |   |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 hours<br>3 days<br>14-21 days |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |   |   |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |   |   |
| 22a. I certify that (X) (this hospital) attended the deceased from 11/14, 19 80, to 11/15, 19 80, that (X) (we) last saw the deceased alive on 11/15, 19 80, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did not) view the body after death.   |  |   |   |  |  |  |  |   |   |
| 22b. SIGNATURE Dennis R. Ward, M.D.  |  |   |   | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                   |  | 22c. DATE SIGNED 11/15/80  |  |   |   |
| 22d. PHYSICIAN'S NAME (Type) Dennis R. Ward, M.D.  |  |   |   | 22e. ADDRESS 3100 Wyman Park Drive, Balt., MD 21211  |  |  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL   |  | 23b. DATE 11-18-80  |   | 23c. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE CEM.  |  | 23d. LOCATION (City or Town) ELKBRIDGE (County) (State) MD.                                  |  |   |   |
| 24. FUNERAL DIRECTOR Charles S. Gailer & Son, Inc.   |  | 901 S. CONKLING ST. BALTO., 21224, MD.  |   | 25a. REC'D BY REGISTRAR DATE NOV 17 1980   |  | 25b. REGISTRAR'S SIGNATURE   |  |   |   |



NOV 11 1964  
U.S. DEPARTMENT OF THE ARMY  
WASHINGTON, D.C.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 7 8 3 7

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|   |   |  |   |  |   |
|---|---|--|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Ruby SARAH Baugher  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 21 80                               |  | 2b. HOUR<br>8 30 AM   |
| 3 SEX<br>FEMALE   | 4 RACE<br>WHITE   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>10-24-1897  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>83 YRS                                      | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VIRGINIA   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                    |  |   |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BALTO. CITY HOSPITAL |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE | 12b. KIND OF BUSINESS OR INDUSTRY<br>—   |   |
| 13a. STATE<br>MD.   |   |  | 13b. COUNTY<br>BALTO.   | 13c. CITY OR TOWN<br>DUNDALK   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                               |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>— UNK —   |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>— UNK NEWTON                 |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO.   |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>725-50-0007D  | 17. INFORMANT<br>ADDRESS<br>AUBREY G. BAUGHER - AS 13C                        |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Multiple Organ Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Subdural hematoma</u>     |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.  |   |  |   |  |   |
| 19a. DATE OF OPERATION<br>11/10/80  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Subdural hematoma  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>               | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>1:30 P.M. 11 10 1980  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br>Fell down stairs |   |
| 21d. INJURY OCCURRED<br>AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/><br>AT HOME <input checked="" type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>Home   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>3412 Dunhaven Rd Balt MD                      |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/10 to 11/21/80, that (I) (we) last saw the deceased alive on 11/20/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. |   |  |   |  |   |
| 22b. SIGNATURE<br>A. S. FARRUKH   |   | DEGREE<br>MD   |   | 22c. DATE SIGNED<br>11/21/80   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>A. S. FARRUKH  |   | 22e. ADDRESS<br>6810 Bonnie Ridge Dr Balt Md 21209   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  | 23b. DATE<br>11/24/1980   | 23c. NAME OF CEMETERY OR CREMATORY<br>HOLLY MEM. GRDN.   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>CHARLOTTESVILLE, VA.                                 |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>WALTER BROOKS BRADLEY, DUNDALK, MD  |   | ADDRESS<br>NOV 28 1980   |   |  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.



RECEIVED 1960

NOV 28 1960

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

2 7 8 3 8

REG. NO.

1. FOR  
STATE  
REGISTRAR1. DECEASED NAME  
(TYPE OR PRINT)FIRST MIDDLE LAST  
Marie

Bayer

2a. DATE OF DEATH MONTH DAY YEAR  
November 28, 19802b. HOUR  
2:30A M

3. SEX

Female

4. RACE

White

5. DATE OF BIRTH

MONTH DAY YEAR  
May 13 1912

6. AGE (IN YEARS LAST BIRTHDAY)

68

IF UNDER 1 YEAR

MONTHS DAYS

IF UNDER 24 HRS

HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City

MD.

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Maryland General Hospital

12a. USUAL OCCUPATION  
(TYPE OF WORK FOR MOST OF WORKING LIFE)

Homemaker

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE  
Md.

13b. COUNTY

13c. CITY OR TOWN  
Balto.13d. INSIDE CITY LIMITS?  
YES ☒ NO ☐13e. STREET ADDRESS  
4010 4th Street

14. FATHER'S NAME

FIRST MIDDLE LAST  
Robert

Moore

15. MOTHER'S MAIDEN NAME

FIRST MIDDLE LAST  
Mary

McCormick

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO OR UNKNOWN)

NO

16b. SOCIAL SECURITY NO.  
(IF YES, GIVE WAR OR DATES)

218 76 4892

17. INFORMANT

ADDRESS

Margaret Vogel 4010 4th Street Balto.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardio-Pulmonary Arrest

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

8 Days

4360

DUE TO, OR AS A CONSEQUENCE OF

(b) Left Cerebral Vascular Accident

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐20b. IF YES, WERE FINDINGS USED  
IN CERTIFYING CAUSES OF DEATH?  
YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION  
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that ☒ (this hospital) attended the deceased from November 20, 1980, to November 28, 1980, that ☒ (we) lost  
saw the deceased alive on November 28, 1980, and that in ☒ (our) opinion death occurred on the date and hour and from the causes stated  
above, ☒ (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

22c. DATE SIGNED

11/28/80

Antonio E. Tauler, M.D.

ATTENDING  
PHYSICIAN ☐MEDICAL  
DIRECTOR ☐STAFF  
PHYSICIAN ☐

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Antonio E. Tauler, M.D.

22e. ADDRESS

c/o Maryland General Hospital

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

Burial

23b. DATE

12/1/80

23c. NAME OF CEMETERY OR CREMATORY

Cedar Hill Cemetery

23d. LOCATION  
CITY OR TOWN

Brooklyn

COUNTY

A.A.

STATE

Md.

24. FUNERAL DIRECTOR

NAME

George J. Gonce 4001 Ritchie Hwy.

Balto 21225

25a. DATE REC'D. BY REGISTRAR

DEC 2 1980

25b. REGISTRAR'S SIGNATURE

Rafael M. Brady

•

Items 1, 14 g549 11/24/80 gj

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 7 8 3 9

REG. NO.

|   |  |  |   |  |  |   |  |   |  |  |  |
|---|--|--|---|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>John Edward Beard Jr.  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 4, 1980 |  |  | 2b. HOUR<br>8:30p AM  |  |   |  |  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Caucasian   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Oct. 26, 1917  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>63 YRS   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS   |  | 8. IF UNDER 24 HRS<br>HOURS MIN.             |  |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 10. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 11. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 12. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore MD.  |  |   |  |  |  |
| 13. CITY OR TOWN OF DEATH<br>Baltimore  |  | 14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>U.S. Public Health Service Hospital |   |  |  | 15. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Seaman   |  |   | 16. KIND OF BUSINESS OR INDUSTRY<br>Maritime |  |  |
| 17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>17a. STATE<br>Maryland   |  |  |   |  |  | 17b. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 17c. STREET ADDRESS<br>P.O. Box 234,  |  |  |  |
| 18. FATHER'S NAME<br>John   |  | 19. MOTHER'S MAIDEN NAME<br>Mary E. Lare   |   | 20. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>yes   |  | 21. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>214 10 3420  |  | 22. INFORMANT ADDRESS<br>U.S.P.H.S. Hospital records  |  |  |  |
| 23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>secondary to Pulmonary emboli</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |  |   |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |  |  |   |  |   |  |  |  |
| 24. DATE OF OPERATION   |  | 25. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  |  | 26. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 27. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 28. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 29. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 30. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |  |  |
| 31. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 32. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 33. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |  |  |
| 34. I certify that (I) (this hospital) attended the deceased from <u>November 2</u> 19 <u>80</u> to <u>November 4</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>November 4</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |   |  |   |  |  |  |
| 35. SIGNATURE<br><u>Frank Devera</u>  |  |  |   |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 36. DATE SIGNED<br>11/4/80  |  |  |  |
| 37. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Frank Devera, M.D.  |  |  |   |  |  | 38. ADDRESS<br>U.S.P.H.S. Hospital, Baltimore, Maryland 212   |  |   |  |  |  |
| 39. BURIAL, CREMATION, REMOVAL<br>(IF OTHER)  |  | 40. DATE<br>11/8/80  |   | 41. NAME OF CEMETERY OR CREMATORY<br>Union Chapel Cem.   |  | 42. LOCATION<br>CITY OR TOWN  |  | 43. STATE<br>Fred. Md.  |  |  |  |
| 44. FUNERAL DIRECTOR<br>G. Douglas Stauffer Rt. 10  |  |  |   |  |  | 45. DATE REC'D. BY REGISTRAR<br>NOV 10 1980   |  | 46. REGISTRAR'S SIGNATURE<br><u>R. J. [Signature]</u>   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 2 7 8 4 0  
CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |   |  |   |  |
|---|--|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Frank William Beavers                |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 6, 1980 |   |  | 2b. HOUR<br>2:27A M   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Caucasian  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>August 2, 1923  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>57   |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>West Virginia                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1325 Church Street |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Dispatcher                  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>-----  |   | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Unknown Beavers                   |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Nancy Howell   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE YEAR OR DATES)<br>WW 11 236-28-1689   |   | 17. INFORMANT<br>ADDRESS<br>Mr. Robert F. Beavers Balt., Md., 21222<br>215 Riverview Ave.,  |  |   |  |

|   |  |   |
|---|--|---|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u><br>424/ } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which } (b) <u>Aortic Valve disease</u><br>gave rise to immediate }<br>cause (a), stating the }<br>underlying cause lost. }<br>(c) _____ |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
|---|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  
Chronic Obstructive Airway Disease

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/27/80</u> to <u>10/27/80</u> , that (I) <u>lost</u><br>saw the deceased alive on <u>10/27/80</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <u>has</u> (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><u>Richard E. Fisher MD</u>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><u>11/6/80</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>RICHARD E. FISHER</u>  |  |  |  | 22e. ADDRESS<br><u>4700 Rivington Ave. 21226</u>   |  |   |  |

|   |  |                      |  |  |  |   |  |
|---|--|----------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>11/8/80 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Glen Haven Mem. Park |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Glen Burnie AA Maryland |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Mc Cully Funeral Home of Bk.</u><br><u>237 E. Patapsco Avenue Baltimore, Md. 21201</u> |  |                      |  | 25a. DATE REC'D. BY REGISTRAR<br><u>NOV 12 1980</u>        |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                      |  |









4

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 7 8 4 1

REG. NO.

|   |  |   |   |   |   |  |  |  |     |  |
|---|--|---|---|---|---|--|--|--|-----|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>MARGARET MAE BECKER</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 / 2 / 80</b> |   |   | 2b. HOUR<br>MIN.<br><b>10<sup>10</sup> P.M.</b>  |  |  |     |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Caucasian</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 17 1897</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br><b>83</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |     |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>  |  |  | MD. |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Deaton Medical Center</b> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                |     |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>A.A. Co.</b>  |   | 13c. CITY OR TOWN<br><b>Glen Burnie</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>303 6th Ave. N.E.</b>                  |     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Ozman</b>   |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Taylor</b>  |   |  |  |  |     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT<br>ADDRESS<br><b>Balto 21227</b>  |   | August J. Becker 2910 Ohio Ave.  |  |  |     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cirrhosis of the liver</b><br><b>5715</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Hepatic encephalopathy</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                     |     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |   |   |  |  |  |     |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |  |     |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |     |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Oct. 10</b> , 19 <b>80</b> , to <b>Nov. 2</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>Nov. 2</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                       |  |   |   |   |   |  |  |  |     |  |
| 22b. SIGNATURE<br><b>Julian W. Reed M.D.</b>  |  |   |   | DEGREE<br><b>M.D.</b>   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11/3/80</b>                               |     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JULIAN W. REED</b>  |  |   |   | 22e. ADDRESS<br><b>611 S. CHAS. ST. BALTO. MD. 21230</b>  |   |  |  |  |     |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>11/5/80</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem Pk</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glen Burnie A.A. Md.</b>  |  |  |     |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>George J. Gonce</b>  |  |   |   | ADDRESS<br><b>4001 Ritchie Hgwy.</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 5 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Henry McBratney</b>             |     |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



John

no

James

Albion City

Jan 12 1897

303 6th Ave. N.E.

Albion

1897

James J. Becken 310 Ohio Ave.

James J. Becken 310 Ohio Ave. Jan 12 1897

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |                        |  |  |  |  |  |   |   |   |  |
|--|--|------------------------|--|--|--|--|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARY K. BEHRINGER</b>   |  |                        | 2a. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>1</b> YEAR <b>80</b>   |  |  | 2b. HOUR<br><b>12:25 P</b>   |  |   |   |   |  |
| 3 SEX<br><b>FEMALE</b>   |  | 4 RACE<br><b>WHITE</b> |  | 5. DATE OF BIRTH<br>MONTH <b>12</b> DAY <b>17</b> YEAR <b>89</b> |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>90</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>                              |   | IF UNDER 24 HRS.<br>HOURS <b></b> MIN. <b></b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  |                        | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD   |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  |                        | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b> |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Packing Clerk</b>   |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Gibbs Co.</b>   |   |  |
| 13a. STATE<br><b>Maryland</b>  |  |                        |  |  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Edgemere</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14 FATHER'S NAME<br>FIRST <b></b> MIDDLE <b></b> LAST <b>Kist</b>  |  |                        |  |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST <b></b> MIDDLE <b></b> LAST <b>Not Known</b>  |  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |                        | 16b. SOCIAL SECURITY NO.<br><b>217-07-3538</b>   |  |  | 17 INFORMANT<br><b>Marge Behringer</b>   |  |   | ADDRESS <b>2549 East Ave. - Balto. MD 21219</b>   |   |  |
| 18 CAUSE OF DEATH Enter only one cause per line (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Anaerobes sepsis</b><br>4860<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Pneumonia - Pneumo Epyema</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b> |  |                        |  |  |  |  |  |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                        |  |  |  |  |  |   |   |   |  |
| 19a. DATE OF OPERATION   |  |                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                        | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19 <b>80</b>   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |                        | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   | 21g. <b>10/13</b> 19 <b>80</b> to <b>11/1</b> 19 <b>80</b> , that (I) (we) lost<br>saw the deceased alive on <b>11/1</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |   |  |
| 22b. SIGNATURE<br><b>BICH T DUONG</b>  |  |                        | DEGREE<br><b>MD</b>  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                 |  |   | 22c. DATE SIGNED<br><b>11/1/80</b>  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BICH T DUONG</b>   |  |                        | 22e. ADDRESS<br><b>ST AGNES HOSPITAL</b>   |  |  | <b>900 CATON AVE.</b>  |  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |                        | 23b. DATE<br><b>11/4/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sacred Ht. of Jesus</b> |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Dundalk, Baltimore, MD</b> |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Duda-Ruck, Inc.</b> ADDRESS <b>7922 Wise Avenue, Dundalk, MD 21222</b>   |  |                        |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 5 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>L. J. [Signature]</b>                      |   |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

2 7 8 4 3

REG. NO.

1 DECEASED NAME  
(TYPE OR PRINT)ELLEN LOUISE BELL  
FIRST MIDDLE LAST  
ELLEN L. BELL2a DATE OF DEATH MONTH DAY YEAR 2b HOUR  
11/14/80 2:30 AM

3 SEX

FEMALE

4 RACE

WHITE

5 DATE OF BIRTH

MONTH DAY YEAR  
11 14 19

6 AGE (IN YEARS LAST BIRTHDAY)

61

IF UNDER 1 YEAR

MONTHS DAYS

IF UNDER 24 HRS

HOURS MIN.

7a BIRTHPLACE (STATE OR FOREIGN  
COUNTRY)

Maryland

7b CITIZEN OF WHAT COUNTRY?

U.S.A.

8 MARRIED ☐ NEVER MARRIED ☐  
WIDOWED ☒ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City, MD

10 CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Good Samaritan Hospital

12a USUAL OCCUPATION  
(TYPE OF WORK FOR MOST OF WORKING LIFE)

Housewife

12b KIND OF BUSINESS OR  
INDUSTRY

Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE

Maryland

13b COUNTY

Baltimore

13c CITY OR TOWN

21234

13d INSIDE CITY LIMITS?

YES ☐ NO ☒

13e STREET ADDRESS

1408 Dartmouth Avenue

14 FATHER'S NAME

George

MIDDLE

LAST

Harmon

15 MOTHER'S MAIDEN NAME

Helen

MIDDLE

LAST

Pyle

16a WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO OR UNKNOWN)

No

16b SOCIAL SECURITY NO  
(IF YES, GIVE WAR OR DATES)

-----

216-12-0690

17 INFORMANT

ADDRESS

William R. Stover Baltimore, Md.

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

1991

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause lost

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY?

YES ☐ NO ☐20b. IF YES, WERE FINDINGS USED  
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d INJURY OCCURRED

WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION  
STREET

CITY OR TOWN

COUNTY

STATE

22a I certify that (I) (this hospital) attended the deceased from 11/13/80 19 to 11/14/80 19, that (I) (we) last  
saw the deceased alive on 11/14/80 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  
above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE

Edward Maung-U.

DEGREE

M.D.

ATTENDING  
PHYSICIAN ☐MEDICAL  
DIRECTOR ☐STAFF  
PHYSICIAN ☒

22c DATE SIGNED

11/14/80 2:30 PM

22d PHYSICIAN'S NAME (TYPE OR PRINT)

EDWARD MAUNG-U.

22e ADDRESS

The Good Samaritan Hospital  
5601. Loch Raven Blvd. Balto. 2123423a BURIAL, CREMATION, REMOVAL  
(SPECIFY)

Burial

23b. DATE

Nov. 17, '80

23c. NAME OF CEMETERY OR CREMATORY

Dulaney Valley Mem. Gar. Balto. Co., Md.

23d. LOCATION  
CITY OR TOWN

COUNTY

STATE

24 FUNERAL DIRECTOR

NAME

William E. Johnson 8521 Loch Raven Blvd.

ADDRESS

25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

NOV 17 1980

Edward Maung-U.

BP  
DHMH-16 20M  
(VRA 15, 4) 7/78TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

4914



*Handwritten signature or initials.*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

2 7 8 4 4

REG. NO.

FOR  
STATE  
REGISTRAR

|   |   |   |   |  |  |
|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>WILLIAM H. BELL</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11/10/80</b>                              |  | 2b. HOUR<br><b>0812 P.M.</b>   |
| 3. SEX<br><b>M</b>  | 4. RACE<br><b>Black</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11. 20 99</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS.                              | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>ne</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.              |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Maternal</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Chemical</b>                           |  |
| 13a. STATE<br><b>md</b>   |   |   | 13b. COUNTY<br><b>Balt</b>  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Wendman</b>  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Phillis ?</b>                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>244-16-4905</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Laurel Bell</b>                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardio respiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Brain tumor - no metastasis from prostate 3 months</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>1850</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |   |   |   |  |  |
| 19a. DATE OF OPERATION<br><b>11/6/80</b>  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Brain tumor</b>  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/30</b> , 19 <b>80</b> , to <b>11/10</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>11/10</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |   |   |   |  |  |
| 22b. SIGNATURE<br><b>Mark Bell</b>  |   | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>11/10/80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MARK BELL</b>   |   | 22e. ADDRESS<br><b>UNION MEMORIAL HOSPITAL</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   | 23b. DATE<br><b>11, 14, 80</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mid. National Cem</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Laurel md</b>                 |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Laurel H. Cawell</b>   |   | ADDRESS<br><b>Balt. Md</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 12 1980</b>                            | 25b. REGISTRAR'S SIGNATURE<br><b>Perryman</b>  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

WILLIAM H. BELL

BALTIMORE CITY

UNION MEMORIAL HOSPITAL

BALTIMORE

UNION MEMORIAL HOSPITAL

MARK BELL

NOV 15 1950



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

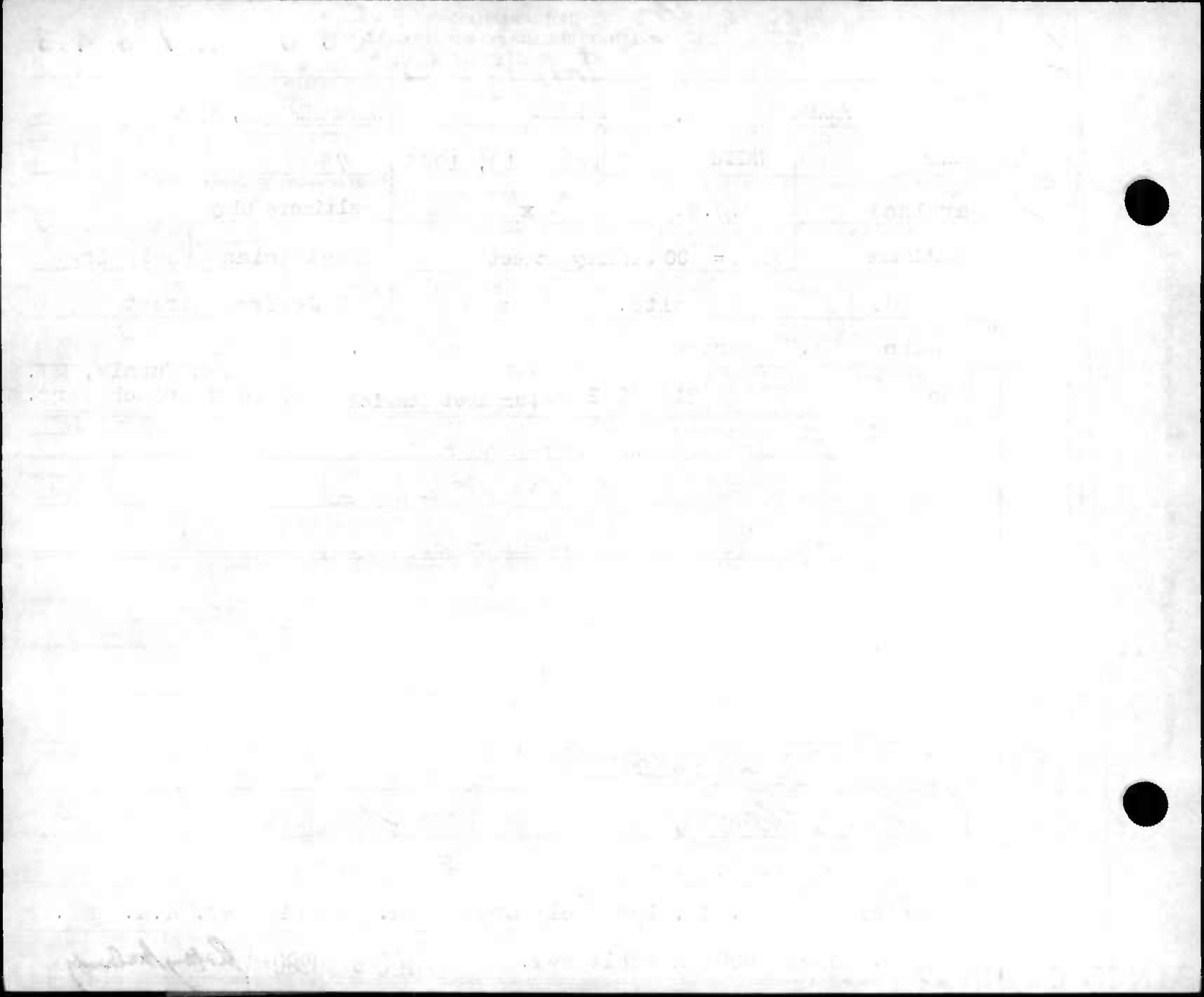
6

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 7 8 4 5

REG. NO.

|  |  |   |  |  |                      |   |  |  |  |  |  |
|--|--|---|--|--|----------------------|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>FRANK W. BEMRICK</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>NOVEMBER 25, 1980</b> |  | 2b. HOUR<br><b>M</b> |   |  |  |  |  |  |
| 3 SEX<br><b>MALE</b>   |  | 4 RACE<br><b>WHITE</b>  |  | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>Feb 13, 1905</b>  |                      | 6 AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>75</b>  |  | 7 UNDER 1 YEAR<br>MONTHS DAYS<br><b>75</b>   |  | 7 UNDER 24 HRS<br>HOURS MIN.<br><b>75</b>    |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7c. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>HOME = 600 Jeffrey Street</b> |  |  |                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Electrician</b>          |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Shipping</b>   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Balto.</b>  |  | 13c. CITY OR TOWN<br><b>Balto.</b>   |                      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>600 Jeffrey Street</b>   |  |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John R. Bemrick</b>  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary M. McDonald</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |                      |   |  |  |  |  |  |
| 16b. SOCIAL SECURITY NO<br><b>213 01 2346</b>  |  | 17 INFORMANT<br><b>Margaret Bemrick</b>   |  | ADDRESS <b>8067 Long Branch Terr. Glen Burnie, Md.</b>   |                      |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Resp. Failure</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Emphysema</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASCOD -</b> |  |   |  |  |                      |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c).  |  |   |  |  |                      |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |                      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                      |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                      |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/18/77</b> 19____, to <b>04/20/80</b> 19____, that (I) (we) last saw the deceased alive on <b>Oct 20/80</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                     |  |   |  |  |                      |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>[Signature]</b>   |  | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                 |                      |   |  | 22c. DATE SIGNED<br><b>11/25/80</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>C. M. PATA LINSHCUB</b>  |  | 22e. ADDRESS<br><b>403 E. PATAPSCO 21225</b>  |  |  |                      |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Nov. 28, 1980</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Cross Cem.</b>   |                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Ritchie Hwy. A.A. Md.</b>                      |  |  |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>George J. Gonce</b>  |  | ADDRESS<br><b>4001 Ritchie Hwy.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 2 1980</b>   |                      | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |  |  |  |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 27846

REG. NO.

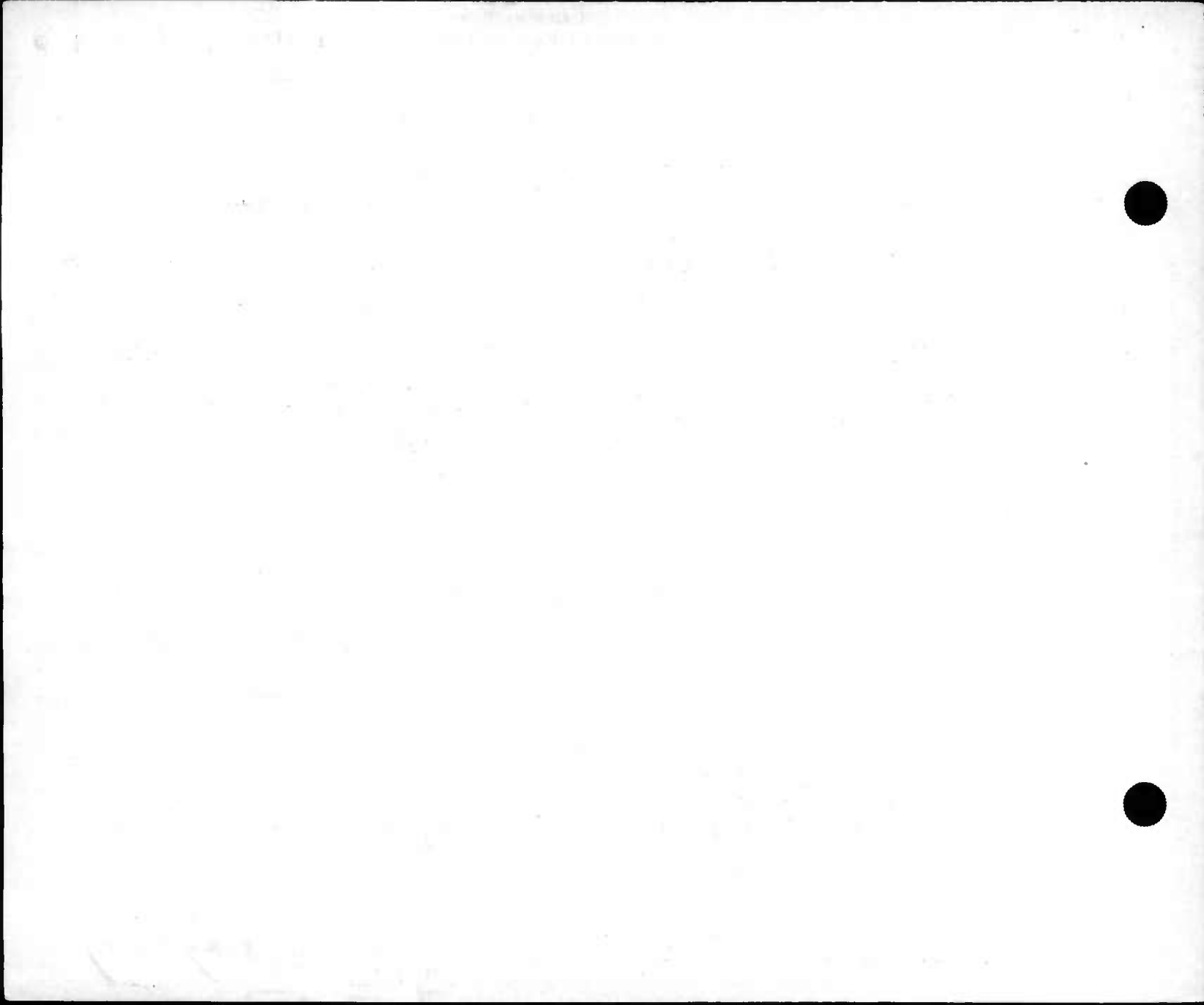
FOR  
1 - STATE  
REGISTRAR

|   |   |   |   |   |   |  |
|---|---|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>WILFORD G. BENNETT, JR.  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 6 80                                      |   | 2b. HOUR<br>11:50 AM                              |  |
| 3. SEX<br>M   | 4. RACE<br>Caucasian  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 7 26  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>54   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New York   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Sinai Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Administrator - |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Nursing Home |  |
| 13a. STATE<br>MD  |   | 13b. COUNTY<br>-  | 13c. CITY OR TOWN<br>Baltimore  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Wilford G. Bennett, Sr.   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lillian Quigley  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |   | 16b. SOCIAL SECURITY NO<br>WW II 217-24-5618  |   | 17. INFORMANT<br>Mrs. Evelyn R. Bennett<br>3931 Penhurst Ave., Baltimore, MD 21215              |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1: DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Ac. Myocardial infarction</u><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ASHD</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH<br>2 PM. |   |   |   |   |   |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>old MI (1978)</u>   |   |   |   |   |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 16 1966</u> to <u>Nov 6 1980</u> , that (I) (we) last saw the deceased alive on <u>Nov 6 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |   |   |   |   |   |  |
| 22b. SIGNATURE<br><u>Daniel Bakal</u>   |   | DEGREE<br><u>MD</u>   |   | 22c. DATE SIGNED<br>11.6.80   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Daniel Bakal M.D.  |   | 22e. ADDRESS<br>Sinai Hospital, Baltimore, MD 21215   |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |   | 23b. DATE<br>11/10/80   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Woodlawn Cemetery   |   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Woodlawn Baltimore MD   |   | 23e. NAME OF FUNERAL DIRECTOR<br>Loring Byers Funeral Directors, P.A.   |   | 23f. ADDRESS<br>8728 Liberty Rd., Randallstown, MD 21133  |   |  |
| 23g. DATE REC'D. BY REGISTRAR<br>NOV 7 1980   |   | 23h. SIGNATURE<br><u>Loring Byers</u>   |   |   |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |         |   |  |
|--|---------|---|--|
| 1- STATE REGISTRAR   |         | 8 0 2 7 8 4 7   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | 2a. DATE KNOWN OF DEATH   |  |
| FIRST MARY MIDDLE G. LAST Berardino  |         | ESTIMATED <input checked="" type="checkbox"/> MONTH 11 DAY 13 YEAR 80 |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH  | 6. AGE (IN YEARS)  |
| Female   | White   | MONTH 9 DAY 6 YEAR 32   | LAST BIRTHDAY 48 YRS.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| Maryland   |         | U.S.A.  | Baltimore City   |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION              |  |
| Baltimore  |         | Bon Secours Hospital  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |         | 12b. KIND OF BUSINESS OR INDUSTRY                                     |  |
| Homemaker  |         |   |  |
| 13a. STATE   |         | 13b. COUNTY   | 13c. CITY OR TOWN  |
| Maryland   |         |   | Baltimore  |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME  |  |
| FIRST MIDDLE LAST John MACHLINSKI  |         | FIRST MIDDLE LAST Agnes Bew   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |         | 16b. SOCIAL SECURITY NO.  | 17. INFORMANT  |
| NO   |         | 212-30-0394   | George S. Berardino, Sr.   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                          |  |
| PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease  |         |   |  |
| 4292 } CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a) STATING THE UNDERLYING CAUSE LAST.   |         |   |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF   |         |   |  |
| (c) DUE TO, OR AS A CONSEQUENCE OF   |         |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |         |   |  |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                     |  |
|  |         |   |  |
| 20. AUTOPSY?   |         |   |  |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |         |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         | 21b. TIME OF INJURY   |  |
|  |         | HOUR A.M. MONTH DAY YEAR  |  |
|  |         | P.M. 19   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)           |  |
|  |         |   |  |
| 21f. LOCATION  |         | CITY OR TOWN COUNTY STATE   |  |
|  |         |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |   |  |
| ACTUAL SIGNATURE   |         | TITLE (SPECIFY)   |  |
| Margarita A. Korell  |         | Assistant   |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |         | DATE SIGNED   |  |
| Margarita A. Korell, M.D.  |         | 11-14-80  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         | 23b. DATE   | 23c. NAME OF CEMETERY OR CREMATORY   |
| Burial   |         | 11/17/80  | Gardens of Faith   |
| 24. FUNERAL DIRECTOR   |         | 23d. LOCATION   |  |
| Hubbard Funeral Home, Inc.   |         | CITY OR TOWN COUNTY STATE   |  |
| Balto., Md. 21229  |         | Parkville Maryland  |  |
| 25a. DATE REC'D. BY REGISTRAR  |         | 25b. REGISTRAR'S SIGNATURE  |  |
| NOV 17 1980  |         | [Signature]   |  |



1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 7 8 4 8

REG. NO.

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Jeannette W Bernaerts</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 06, 1980</b>                       |  | 2b. HOUR<br>MIN.<br><b>08:52pm</b>   |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5-12-1925</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>55</b> YRS.                                    | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>The Netherlands</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>The Johns Hopkins Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Accounting</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Real Estate Co.</b>                          |  |
| 13a. STATE<br><b>MD.</b>   |  |   | 13b. COUNTY<br><b>A.A.</b>  | 13c. CITY OR TOWN<br><b>Annapolis</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Unknown Bouter</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>                       |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>044-32-2192</b>  | 17. INFORMANT<br>ADDRESS<br><b>Henry T. Bernaerts - Sec. 13</b>                       |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>septic shock</b><br>2030<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>multiple myeloma</b><br>(c) <b>4 yrs</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b> |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)        |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                     |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/16</b> , 19 <b>80</b> , to <b>11/6</b> , 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>11/6</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |  |  |
| 22b. SIGNATURE<br><b>DALE RENNOLD</b>  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   | 22c. DATE SIGNED<br><b>11/6/80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DALE RENNOLD</b>   |  | 22e. ADDRESS<br><b>601 N. Broadway, Baltimore</b>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>   | 23b. DATE<br><b>11-8-80</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Crematory</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Westview Balto MD.</b>              |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Robert S. Barranco</b>  |  | ADDRESS<br><b>501 Ritchie Ave Severna Park</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 13 1980</b>                                  | 25b. REGISTRAR'S SIGNATURE<br><b>Henry McCreedy</b>  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be filled in by the funeral director. It should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8 0 2 7 8 4 9  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Anna Bernstein</b>  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 11 80</b>   |  | 2b. HOUR<br><b>2:15 AM</b>   |  |
| 3. SEX<br><b>♀ FEMALE</b>  |  | 4. RACE<br><b>W WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 10 101</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74 78</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sinai Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SECRETARY</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>CITY OF. BALTO.</b>  |  |
| 13a. STATE<br><b>MD.</b>   |  |  |  | 13b. COUNTY<br><b>BALTO.</b>   |  | 13c. CITY OR TOWN<br><b>RANDALLSTOWN</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>DAVID BERNSTEIN</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ROSA UNKNOWN</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>219-28-1583</b>  |  | 17. INFORMANT<br><b>IRVING COHN, ASTY.</b><br><b>326 ST. PAUL PLACE BALTO., MD 21202</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CHF</b><br><b>4280</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH               |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) <u>this hospital</u> attended the deceased from <u>9/19</u> 19 <u>80</u> , to <u>11/11</u> 19 <u>80</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>12-AM 11/1</u> 19 <u>80</u> , and that in <u>(my)</u> <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above <u>(I)</u> <u>(we)</u> <u>(did)</u> <u>(did not)</u> view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Allen Hettelman MD</b><br>DEGREE  |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  | 22c. DATE SIGNED<br><b>11/1/80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Allen Hettelman MD</b>   |  |  |  | 22e. ADDRESS<br><b>Sinai Hospital</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>11/4/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HEBREW FRIENDSHIP</b>   |  | 23d. LOCATION<br>BALTIMORE COUNTY MARYLAND   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b><br>ADDRESS<br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 5 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Esther M. Bandy</b>   |  |

MEDICAL CERTIFICATION

BP



*Handwritten signature*

00814 VED

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 7 8 5 0

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |   |  |   |   |   |  |  |  |
|---|--|---|--|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Rebecca F. Berry   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11/30/80                        |   |   | 2b. HOUR<br>9:00am  |  |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Black  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2 3 34  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>46 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 9. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 11. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore, Maryland MD                                 |  |  |  |
| 12. CITY OR TOWN OF DEATH<br>Baltimore  |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Johns Hopkins Hospital |  |   |   | 14. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                 |  | 15. KIND OF BUSINESS OR INDUSTRY   |  |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>16a. STATE<br>Maryland   |  | 16b. COUNTY<br>Baltimore  |  | 16c. CITY OR TOWN<br>Baltimore  |   | 16d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 16e. STREET ADDRESS<br>905 N. Rose Street  |  |
| 17. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Gary  |  |   |  | 18. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Rosalee Storgis  |   |   |  |  |  |
| 19a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |  | 19b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>8/7/43  |  | 20. INFORMANT<br>Calvin H. Berry  |   | 20a. ADDRESS<br>905 N. Rose Street  |  |  |  |
| 21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Subarachnoid hemorrhage</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Berry aneurysm</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>hypertension</u><br>4300<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>36 hrs<br>36 hrs<br>year |  |   |  |   |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):   |  |   |  |   |   |   |  |  |  |
| 21a. DATE OF OPERATION  |  |   | 21b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 22a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 22b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 23a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 23b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 23c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |  |  |
| 24a. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |   | 24b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 24c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 25. I certify that (I) (this hospital) attended the deceased from <u>11-28</u> , 19 <u>80</u> , to <u>11-30</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>11/30</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |  |   |   |   |  |  |  |
| 26. SIGNATURE<br><u>William T. Kelley M.D.</u>  |  |   |  |   |   | 26a. DEGREE<br>M.D.   |  | 26b. DATE SIGNED<br>11/30/   |  |
| 27. PHYSICIAN'S NAME (TYPE OR PRINT)<br>William T. Kelley M.D.  |  |   |  |   |   | 27a. ADDRESS<br>Johns Hopkins Hospital  |  |  |  |
| 28a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |   | 28b. DATE<br>12/5/80   |   | 28c. NAME OF CEMETERY OR CREMATORY<br>Crownsville VA Cemetery |   | 28d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Crownsville MD |  |  |
| 29. FUNERAL DIRECTOR<br>NAME<br>WILLIAM C. MARCH FUNERAL HOME INC.  |  |   |  |   |   | 30. DATE REC'D. BY REGISTRAR<br>DEC 2 1980  |  | 30a. REGISTRAR'S SIGNATURE<br><u>R. Storgis</u>  |  |

DEC 8 1980

*[Handwritten signature]*

**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

8 0 2 7 8 5 1

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|  |   |   |   |   |                                   |
|--|---|---|---|---|-----------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Shelton Bethel</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 7 80</b>   |   | 2b. HOUR<br>M<br><b></b>          |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>Black</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 7 1918</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b>  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.<br> |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S.C.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |   |                                   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2202 E. Biddle Street (Residence)</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |   | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br><b>Maryland</b> | 13b. COUNTY<br><b></b>  | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>2202 E. Biddle Street</b>                 |                                   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Chamberlian Bethel</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Suber</b>  |   |   |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   | 17. INFORMANT<br><b>Sarah Sharpe</b><br>ADDRESS <b>P.O. Box 36</b><br><b>Blythewood S.C. 29016</b>  |   |   |                                   |

**18. CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).  
 PART 1. DEATH WAS CAUSED BY:

|  |   |
|--|---|
| IMMEDIATE CAUSE (a) <b>Respiratory Failure</b>   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>7 months</b> |
| DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Decomposition of the lung</b> | <b>2 months</b>   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Chronic Obstructive Pulmonary Disease</b>   | <b>2 years</b>  |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  
**Malnutrition**

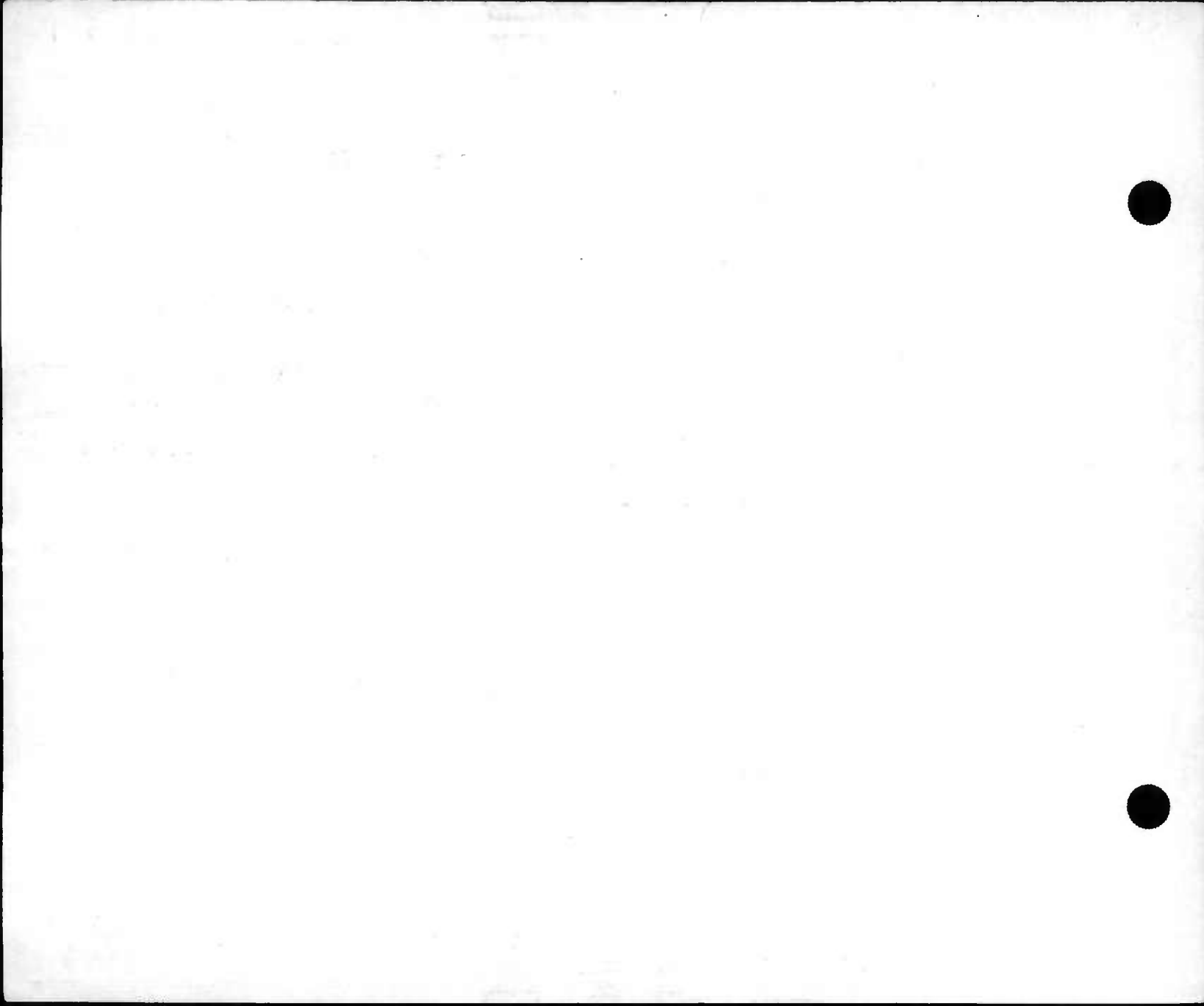
|  |  |  |  |
|--|--|--|--|
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>November</b> 19 <b>79</b> , to <b>Sept. 29</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>Oct. 3</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE<br><b>Thomas A. Pearson M.D.</b>  |  | DEGREE<br><b>M.D.</b>  | 22c. DATE SIGNED<br><b>11/7/80</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Thomas A. Pearson M.D.</b>   |  | 22e. ADDRESS<br><b>Johns Hopkins Hosp.</b>   |  |

|   |           |   |  |
|---|-----------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>             | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY                  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Columbia S.C.</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>William C. March Funeral Home Inc.</b> |           | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 10 1980</b> | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |  |  |  |  |   |  | 8 0 2 7 8 5 2                                       |  |                             |  |
|--|--|---|--|--|--|--|--|---|--|---|--|-----------------------------|--|
| FOR STATE REGISTRAR  |  |   |  |  |  |  |  |   |  | REG. NO.  |  |                             |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Clementine Woods Betts</b>  |  |   |  |  |  |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>11 25 80</b> |  | 2b. HOUR<br><b>3 55 P M</b> |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>BLK</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>10-22-30</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>50</b>  |  | IF UNDER 1 YEAR MONTHS DAYS<br><b>0 0</b>   |  | IF UNDER 24 HRS. HOURS MIN.<br><b>0 0</b>           |  |                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY</b> MD.                                      |  |   |  |   |  |                             |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNIV. OF MD. Hosp.</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |                             |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>BALTO.</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>851 Geo. St. Apt. 3D</b>  |  |   |  |                             |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>217-26-0252</b>   |  | 17. INFORMANT<br><b>WALLACE BETTS</b>   |  | ADDRESS<br><b>SAME</b>                              |  |                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>2875 IMMEDIATE CAUSE (a) Cardio pulmonary Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Acute Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Massive Hemorrhage 2<sup>o</sup> Thrombocytopenia</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH        |  |                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>ETHANOLISM, FRACTURED NOSE.</b>  |  |   |  |  |  |  |  |   |  |   |  |                             |  |
| 19a. DATE OF OPERATION<br><b>NONE</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>-</b>  |  |  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |                             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>1 P.M. 11 24 1980</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>Fall struck nose</b>  |  |  |  |   |  |   |  |                             |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>Home</b>  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br><b>George ST BALTO MD</b>  |  |  |  |   |  |   |  |                             |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11-24</b> , 19 <b>80</b> , to <b>11-25</b> , 19 <b>80</b> , that (I) (we) lost the deceased alive on <b>11-25</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |  |  |   |  |   |  |                             |  |
| 22b. SIGNATURE<br><b>James Benson Hunt MD</b>  |  | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |  |  |  | 22c. DATE SIGNED<br><b>11-28-80</b>   |  |   |  |                             |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JERRY BENSON HUNT MD</b>   |  |   |  | 22e. ADDRESS<br><b>UNIVERSITY Hosp.</b>  |  |  |  |   |  |   |  |                             |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>11/29/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Md. Auburn Cem.</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>BALTO. MD</b>                                  |  |   |  |   |  |                             |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Vernon Bailey</b>  |  |   |  | ADDRESS<br><b>1348 Calhoun St.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 28 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |   |  |                             |  |





STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

REG. NO.

8 0 2 7 8 5 3

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  | 1. DECEASED NAME (AKA FIRST MIDDLE LAST) Anna Bialozenski                       |  | 2a. DATE OF DEATH MONTH DAY YEAR 11 11 80  |  | 2b. HOUR 10 <sup>50</sup> P.M.  |  |
| 3. SEX Female  |  | 4. RACE Caucasian   |  | 5. DATE OF BIRTH MONTH DAY YEAR Feb. 4, 1887   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY? USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.   |  |
| 10. CITY OR TOWN OF DEATH Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Union Memorial Hospital |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife  |  | 12b. KIND OF BUSINESS OR INDUSTRY -   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  | 13a. STATE Maryland  |  |   |  |
| 13b. COUNTY -  |  | 13c. CITY OR TOWN Baltimore   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS 4345 Seidel Ave., 21206   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Casimir - Juras  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Tekla - (unknown)   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No   |  | 16b. SOCIAL SECURITY NO. -  |  | 17. INFORMANT ADDRESS same   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Resp Arrest / Cardiac Arrest                             |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |
| 8842   |  |   |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) multisystem system.   |  |   |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) ACCIDENT  |  |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION 10/2/80   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Hip Ex                         |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                 |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 10 1 1980                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) SUBJ. FELL OUT OF WHEEL CHAIR   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK OR NOT WHILE <input checked="" type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)             |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 4345 SEIDEL AVE. BALTO. MD.   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/1/80 to 11/10/80, that (I) (we) lost the deceased above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |
| 22b. SIGNATURE [Signature]   |  | DEGREE M.D.   |  | 22c. DATE SIGNED 11/11/80  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DOUGLAS ASHENDORF, M.D.   |  |
|  |  | 22e. ADDRESS UNION MEMORIAL HOSPITAL  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial   |  | 23b. DATE 11/15/80  |  | 23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cem.   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.  |  |
| 24. FUNERAL DIRECTOR NAME Schimunek Funeral Home, Inc.   |  | ADDRESS 3331 Brehms Lane Balto., Md. 21213                                      |  | 25. DATE REC'D. BY REGISTRAR NOV 14 1980   |  | 25b. REGISTRAR'S SIGNATURE [Signature]  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



White

Anna

Baltimore City

United Memorial Hospital

Baltimore



RECEIVED

1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |  |  |   |  |  |  |
|---|--|---|--|--|--|---|--|--|--|
| CERTIFICATE OF DEATH  |  |   |  |  |  |   |  |  |  |
| 1. FOR STATE REGISTRAR  |  | REG. NO.  |  |  |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST   |  | MIDDLE   |  | LAST  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR  |  |
| RUTH  |  | Elizabeth   |  | BIEN   |  |   |  | 41 7 80 12-30 <sup>30</sup> AM   |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR   |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | 7. YRS.  |  |
| Female  |  | White   |  | Sept. 28, 1905   |  | 75  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |  |  |
| Balto., Md.   |  | U.S.A.  |  |  |  | Baltimore City, MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| Baltimore   |  | Church Hospital Corporation   |  |  |  | Secretary   |  | Mnfg Window Shades   |  |
| 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS  |  |
| Md.   |  | -----   |  | Baltimore  |  |   |  | 148 N. Potomac Street  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST  |  |   |  |  |  |
| Henry C. Bien   |  |   |  | Annie E. Fetzner   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS  |  |   |  |  |  |
| No  |  | -----   |  | 213-03-5070 Mr. Robert K. Foote-RFD 2-Box 42 A   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>CORONARY ARTERY DISEASE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>-----</u> |  |   |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>CARDIOVASCULAR ACCIDENT; CONGESTIVE HEART FAILURE</u>  |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
|   |  |   |  |  |  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |  |  |
|   |  |   |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
|   |  |   |  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/24</u> , 19 <u>80</u> , to <u>11/7</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>11-6-80</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                              |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><u>XXXXXXXXXX DR. YNARES</u>  |  |   |  | DEGREE<br><u>MD</u>  |  |   |  | 22c. DATE SIGNED<br><u>11-7-80</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>YNARES</u>  |  |   |  | 22e. ADDRESS<br><u>CHURCH HOSPITAL CORPORATION 21231</u><br><u>100 NORTH BROADWAY, BALTIMORE, MARYLAND</u>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |  |  |
| Burial  |  | 11/11/80  |  | Meadowridge Memorial   |  | Park-Howard Cty, Md.  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME  |  |   |  | 25. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |
| John A. Moran, Inc.<br>3000 E Baltimore St.<br>Baltimore, Md 21224  |  |   |  | NOV 10 1980  |  | <u>Anthony McCurdy</u>  |  |  |  |

GOV. COLLEGE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 7 8 5 5

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |  |   |   |   |  |  |  |
|--|--|--|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>John R. Biggs   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 5, 1980         |   | 2b. HOUR<br>10:55 PM  |  |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>May 6, 1901   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>79<br>IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Maryland General Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>custodial guard   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Md House of Correction  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md   |  |  | 13b. CITY OR TOWN<br>Jessup                                     |   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13d. STREET ADDRESS<br>2882 Jessup Road      |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Spear Biggs   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Grace E. Jones |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no   |  | 16b. SOCIAL SECURITY NO.<br>218 36 8435  |   | 17. INFORMANT<br>ADDRESS<br>Cora Biggs same as above  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Abdominal Aneurysm, rupture<br>4413<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |  |  |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>Chronic Renal Failure; Hypotension  |  |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |
| 22a. I certify that (X) (this hospital) attended the deceased from October 27, 19 80, to November 5, 19 80, then (X) (we) lost saw the deceased alive on November 5, 19 80, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (not) view the body after death.                                      |  |  |   |   |   |  |  |  |
| 22b. SIGNATURE<br>Richard D. Boucher, M.D.   |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   | 22c. DATE SIGNED<br>11/5/80  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Richard Boucher, M.D.   |  |  |   | 22e. ADDRESS<br>c/o Maryland General Hospital   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>Nov. 8, 1980  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowridge Memorial Park   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Dorsey, Md   |  |  |
| 24. FUNERAL DIRECTOR<br>Name<br>Donaldson Funeral Home, Laurel, Md   |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 18 1980  |   | 25b. REGISTRAR'S SIGNATURE<br>Dorothy McCreedy   |  |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 27856

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|   |  |  |   |
|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>HAAKON - BJORAA</b>   |  | 2a. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>21</b> YEAR <b>80</b><br>2b. HOUR <b>100PM</b>   |   |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>CAUCASIAN</b>  | 5. DATE OF BIRTH<br>MONTH <b>4</b> DAY <b>16</b> YEAR <b>1902</b>  |   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Norway</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b><br>IF UNDER 1 YEAR: MONTHS <b>-</b> DAYS <b>-</b> HOURS <b>-</b> MIN. <b>-</b><br>IF UNDER 24 HRS: MONTHS <b>-</b> DAYS <b>-</b> HOURS <b>-</b> MIN. <b>-</b> |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sinai Hospital</b> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |   |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD.</b> 13b. CITY OR TOWN <b>Baltimore</b> 13c. CITY OR TOWN <b>Woodlawn</b> 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 12b. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Elevator Operator-retired</b>   |   |
| 14. FATHER'S NAME<br>FIRST <b>Petter</b> MIDDLE <b>-</b> LAST <b>Bjoraa</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Kristine</b> MIDDLE <b>-</b> LAST <b>Bjoraa</b>   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>no</b> (IF YES, GIVE WAR OR DATES) <b>-</b>   |  | 16b. SOCIAL SECURITY NO. <b>336077525</b>  |   |
| 17. INFORMANT<br><b>Hedvick S. Bjoraa</b>   |  | ADDRESS<br><b>21207</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest.</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebrovascular accident</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Pneumonia</b>        |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>-</b>   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>-</b>  |  |  |   |
| 19a. DATE OF OPERATION<br><b>-</b>  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>-</b>   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>-</b>   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>-</b>   | 21f. LOCATION<br>STREET <b>-</b> CITY OR TOWN <b>-</b> COUNTY <b>-</b> STATE <b>-</b>  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/20</b> , 19 <b>80</b> , to <b>11/21</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>11/20</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |
| 22b. SIGNATURE<br><b>Mrd. R. Shariff M.D.</b>   |  | DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>  |   |
| 22c. DATE SIGNED<br><b>11/21/80</b>   |  |  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MOHAMMED R. SHARIEF M.D.</b>  |  | 22e. ADDRESS<br><b>SINAI HOSPITAL, Baltimore</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>  | 23b. DATE<br><b>11/24/80</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Mem. Park</b>  | 23d. LOCATION<br>CITY OR TOWN <b>Catonsville, Balto.</b> COUNTY <b>Md</b> STATE <b>Md</b>   |
| 24. FUNERAL DIRECTOR<br>NAME <b>1630 Edmondson Ave., Catonsville, Md</b><br><b>Witzke Funeral Home of Catonsville, P.A. 21228</b>   |  | 25. DATE REC'D. BY REGISTRAR <b>NOV 25 1980</b> 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |   |

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 and 5 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1000 2 5 1000



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 7 8 5 7

FOR  
1. STATE  
REGISTRAR

REG. NO.

|   |  |  |   |  |                                   |  |  |
|---|--|--|---|--|-----------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST MIDDLE LAST  |   | 2a. DATE OF DEATH MONTH DAY YEAR   |                                   | 2b. HOUR   |  |
| ROOSEVELT   |  | BLACK JR   |   | 11 19 80   |                                   | 10:30A M   |  |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH MONTH DAY YEAR  |   | 6. AGE (IN YEARS LAST BIRTHDAY)  |                                   | IF UNDER 1 YEAR IF UNDER 24 HRS                                |  |
| MALE  | Black  | 1 22 28  |   | 52 YRS   |                                   | MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH   |                                   |  |  |
| TENNESSEE   | U.S.A.   |  |   | BALTIMORE CITY MD.   |                                   |  |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| BALTIMORE   | VAMC, LOCH RAVEN, BALTIMORE, MD  |  | SECURITY OFFICER  |  | STATE HOSPITAL                    |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |   |  |                                   |  |  |
| 13a. STATE  | 13b. COUNTY  | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS?   |                                   | 13e. STREET ADDRESS  |  |
| MARYLAND  |  | BALTIMORE  |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                   | 1625 GLENEAGLE ROAD 21239                                      |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |   |  |                                   |  |  |
| ROOSEVELT   |  | BLACK, SR.   |   | EVA  |                                   | YENCY (YANCEY)   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT  |                                   | ADDRESS  |  |
| YES   |  | WWII   |   | 220 22 2445  |                                   | Pamelia Davis 3005 The Alemedia                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |   |  |                                   |  |  |
| PART 1. DEATH WAS CAUSED BY:  |  |  |   |  |                                   |  |  |
| IMMEDIATE CAUSE (a) <i>Esophageal Ca</i>  |  |  |   |  |                                   |  |  |
| 1629 DUE TO, OR AS A CONSEQUENCE OF   |  |  |   |  |                                   |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Squamous Cell Ca Lung</i>   |  |  |   |  |                                   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |   |  |                                   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |   |  |                                   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?  |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                                   |  |  |
|   |  | P.M. 19  |   |  |                                   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |                                   |  |  |
|   |  |  |   |  |                                   |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>OCTOBER 15</u> 19 <u>80</u> , to <u>NOVEMBER 19</u> 19 <u>80</u> , that <input checked="" type="checkbox"/> (we) lost the deceased alive on <u>NOVEMBER 19</u> 19 <u>80</u> , and that <input checked="" type="checkbox"/> (we) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> view the body after death. |  |  |   |  |                                   |  |  |
| 22b. SIGNATURE  |  | DEGREE   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                   | 22c. DATE SIGNED   |  |
| <i>Norman Goldstein</i>   |  | MD   |   |  |                                   | 11/19/80   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |   |  |                                   |  |  |
| Norman Goldstein  |  | VAMC, 3900 LOCH RAVEN BLVD, BALTO, MD 21218  |   |  |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL   |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY   |                                   | 23d. LOCATION CITY OR TOWN COUNTY STATE                        |  |
| Burial  |  | 11/24/80   |   | MD. NAT. MEM. PK.  |                                   | Laurel MD.   |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS   |  |  |   | 25a. DATE REC'D. BY REGISTRAR  |                                   | 25b. REGISTRAR'S SIGNATURE                                     |  |
| WILLIAM C. MARCH F/H INC. 1101 E. North Ave   |  |  |   | NOV 21 1980  |                                   | <i>Robert M. Hickey</i>  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |                      |  | 8 0 2 7 8 5 8  |     |        |          |
|---|--|--|--|---|--|---|--|----------------------|--|--|-----|--------|----------|
| 1. FOR STATE REGISTRAR  |  | REG. NO.   |  |   |  |   |  |                      |  |  |     |        |          |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST  |  | MIDDLE  |  | LAST  |  | 2a. DATE OF DEATH    |  | MONTH  | DAY | YEAR   | 2b. HOUR |
| AVERY   |  | LEE  |  | BLACKLEY  |  |   |  | 11                   |  | 13   | 80  | 12:45a |          |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS (LAST BIRTHDAY))                                   |  | IF UNDER 1 YEAR      |  | IF UNDER 24 HRS  |     |        |          |
| MALE  |  | BLACK  |  | MONTH DAY YEAR<br>6 21 23   |  | 57  |  | MONTHS DAYS          |  | HOURS MIN.   |     |        |          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                      |  |  |     |        |          |
| NORTH CAROLINIA   |  | U.S.A.   |  |   |  | BALTIMORE CITY, MD.   |  |                      |  |  |     |        |          |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                      |  |  |     |        |          |
| BALTIMORE   |  | VETERANS ADMINISTRATION MEDICAL CENTER   |  |   |  |   |  |                      |  |  |     |        |          |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS  |  |  |     |        |          |
| MARYLAND  |  |  |  | BALTIMORE   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 1739 MCCULLOH ST     |  | 21217  |     |        |          |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  |   |  |   |  |                      |  |  |     |        |          |
| FIRST MIDDLE LAST<br>JOHN   |  | FIRST MIDDLE LAST<br>MARY,   |  |   |  |   |  |                      |  |  |     |        |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS   |  |                      |  |  |     |        |          |
| YES   |  | WWII   |  | 214180458   |  | VA Medical Records  |  | 3900 LOCH RAVEN BLVD |  |  |     |        |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arrhythmia 2° to hyperkalemia + acidosis</u><br>5850<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Chronic renal failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |   |  |   |  |                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>12 hrs<br>years. |     |        |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>none</u>  |  |  |  |   |  |   |  |                      |  |  |     |        |          |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |                      |  |  |     |        |          |
|   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |                      |  |  |     |        |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |                      |  |  |     |        |          |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                 |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |                      |  |  |     |        |          |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>NOVEMBER 12</u> , 19 <u>80</u> , to <u>NOVEMBER 13</u> , 19 <u>80</u> , that (I) (we) lost the deceased on <u>NOVEMBER 13</u> , 19 <u>80</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                |  |  |  |   |  |   |  |                      |  |  |     |        |          |
| 22b. SIGNATURE<br><u>So, MD</u>   |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br><u>11/13/80</u>                                 |  |                      |  |  |     |        |          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>So</u>  |  | 22e. ADDRESS<br><u>3900 LOCH RAVEN BLVD BALTO, MD 21218</u>  |  |   |  |   |  |                      |  |  |     |        |          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>BURIAL</u>  |  | 23b. DATE<br><u>11/18/80</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>CEDARHILL CEMETERY</u>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>BALTIMORE</u>      |  |                      |  |  |     |        |          |
| 24. FUNERAL DIRECTOR<br><u>WILLIAM C. MARCH FUNERAL HOME INC</u>  |  | 1101 East North Ave  |  | 25a. DATE REC'D. BY REGISTRAR<br><u>NOV 14 1980</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Rafael M. [Signature]</u>          |  |                      |  |  |     |        |          |

12

DATE: 12-12-1944

TO: DIRECTOR

FROM: SAC, NEW YORK

SUBJECT: [Illegible]

RE: [Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

1923



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 7 8 6 0

1. FOR STATE REGISTRAR  
HOWARD BLOTTENBERGER

REG. NO.

|  |  |   |  |  |  |  |   |  |  |
|--|--|---|--|--|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Howard M. Blottenberger</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11/29/80</b>                 |  |  | 2b. HOUR<br><b>2:30 A.M.</b>   |   |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8-20-96</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b>                                       |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>84</b>   |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>  |  | 9. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 11. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD</b>                  |   |  |  |
| 12. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST AGNES HOSPITAL</b> |  |  |  | 14. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SALESMAN</b> |   | 15. KIND OF BUSINESS OR INDUSTRY<br><b>FOOD</b>  |  |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN   |  |   |  |  | 17. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |  |
| 18. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Morgan Blottenberger</b>   |  |   |  |  | 19. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Annie Popp</b>                             |  |   |  |  |
| 20. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>Yes</b> (IF YES, GIVE WAR OR DATES) <b>LWI</b>  |  |   |  |  | 21. SOCIAL SECURITY NO.<br><b>215-05-4928</b>  |  |   |  |  |
| 22. INFORMANT<br><b>Mary Blottenberger</b>   |  |   |  |  | 23. ADDRESS<br><b>1718 Chesterton Road</b>   |  |   |  |  |
| 24. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b><br><b>4280</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>congestive heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |   |  |  |  |  |   |  |  |
| 25. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)   |  |   |  |  |  |  |   |  |  |
| 26a. DATE OF OPERATION   |  |   | 26b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  | 27a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>          |   | 27b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 28a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 28b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |  | 28c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)     |   |  |  |
| 29a. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 29b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 29c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                  |   |  |  |
| 30. I certify that (I) (this hospital) attended the deceased from <b>11-21</b> , 19 <b>80</b> , to <b>11-29</b> , 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>11-29</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |  |   |  |  |
| 31. SIGNATURE<br><b>G. Shah</b>  |  |   |  |  | 32. DEGREE   |  | 33. DATE SIGNED<br><b>11/29/80</b>                            |  |  |
| 34. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. G. SHAH</b>   |  |   |  |  | 35. ADDRESS<br><b>900 CATON AVE BALTIMORE MD 21229</b>   |  |   |  |  |
| 36. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |   | 37. DATE<br><b>12/2/80</b>   |  | 38. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b>                                  |  | 39. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. MD</b> |  |  |
| 40. FUNERAL DIRECTOR<br>NAME<br><b>Witzke Funeral Home of Catonsville</b>  |  |   |  |  | 41. DATE REC'D. BY REGISTRAR<br><b>DEC 2 1980</b>  |  | 42. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>               |  |  |
| 43. ADDRESS<br><b>1630 Edmondson Avenue Catonsville, MD 21228</b>  |  |   |  |  |  |  |   |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

11-23-11



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80

27861

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |   |                                       |  |
|--|--|---|---|---|---------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ERVIN N. BLUME</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 9, 1980</b>        |   | 2b. HOUR<br><b>12:50 PM</b>           |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Feb. 14, 1913</b>  |                                       |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>S. Carolina</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>67</b>  |                                       |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |                                       |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Contractor</b>  |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Paint</b>                     |   |                                       |  |
| 13a. STATE<br><b>Maryland</b>  |  |   | 13b. COUNTY<br><b>Baltimore</b>                                       |   | 13c. CITY OR TOWN<br><b>Baltimore</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Keese Blume</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Willie Duncan</b> |   |                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW II</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Sullivan-King Mortuary, S. Carolina</b>  |                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Pneumonia, Empyema</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Poor Nutrition Status</b><br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST:<br><b>2639</b> |  |   |   |   |                                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>Diabetes Mellitus; Wound infection Left hip; Decubitus Ulcers; Left hip fracture</b>  |  |   |   |   |                                       |  |
| 19a. DATE OF OPERATION<br><b>8/4/80</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Jewett Nail Left Femur- fracture</b>   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                |                                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>— P.M. 7 15 1980</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)<br><b>Subject slipped out of bed</b> |                                       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>Home</b>   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>306 W. Franklin Street Baltimore Baltimore MD</b>           |                                       |  |
| 22a. I certify that <b>80</b> (this hospital) attended the deceased from <b>August 1, 1980</b> , to <b>November 9, 1980</b> , that <b>1</b> (we) lost the deceased alive on <b>November 9, 1980</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, <b>1</b> (we) (did) (not) view the body after death.  |  |   |   |   |                                       |  |
| 22b. SIGNATURE<br><b>Antonia M. Chadwick, M.D.</b>   |  |   | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>11/9/80</b>    |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Antonia Chadwick, M.D.</b>   |  |   | 22e. ADDRESS<br><b>c/o 827 Linden Ave. Balto. MD 21201</b>            |   |                                       |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Removal</b>   |  | 23b. DATE<br><b>11/10/80</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Prospect Baptist</b>   |                                       |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Anderson Co., S.C.</b>  |  | 23e. DATE REC'D. BY REGISTRAR<br><b>NOV 12 1980</b>   |   |   |                                       |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Henry W. Jenkins &amp; Sons Co.</b>   |  | 24b. ADDRESS<br><b>4905 York Road Balto., Md. 21212</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Antonia Chadwick</b>   |                                       |  |

4000

VIN 4. 1. 1910

1910, 1. 1. 1910

U. S.

United States

Marshall

William

Yes, it is a very good thing that the United States should have a



11 1910

11 1910

For the United States

For the United States

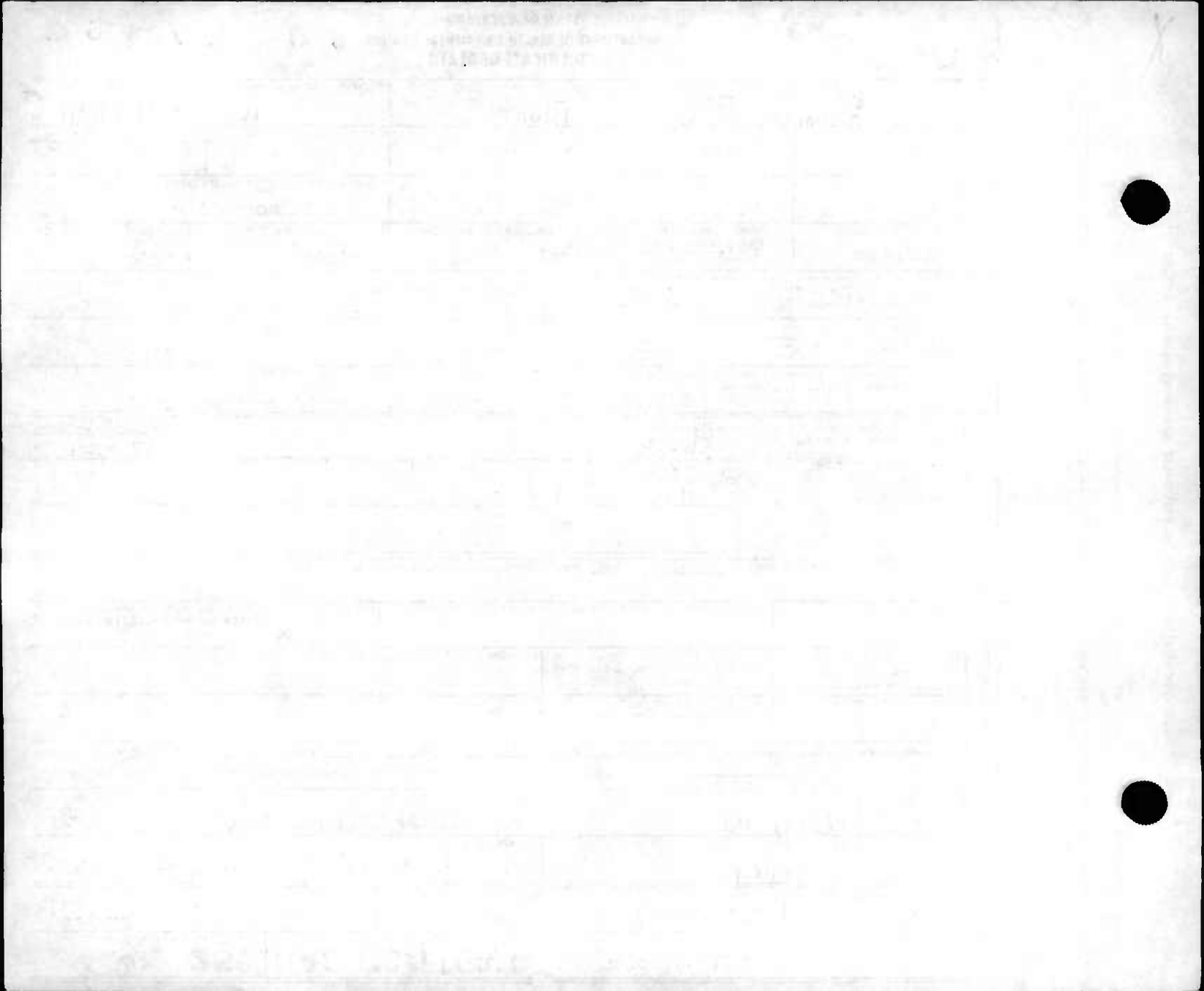
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 0 2 7 8 6 2   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>KENNETH CHARLES BLUNT</b>  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>11-11-80</b>   |  |  |  |
| 3. SEX<br><b>Male</b>   |  |   |  | 2b. HOUR<br><b>11:41 M</b>  |  |  |  |
| 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7/16/1916</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b> YRS  |  | 7. UNDER 1 YEAR<br>MONTHS DAYS<br><b>11 11</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Painter</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Union</b>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Balto.</b>  |  | 13c. STREET ADDRESS<br><b>4154 Eierman Aven. 21206</b>  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William C. Blunt</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Virgie Millekan</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW II 217.01.8092</b>   |  | 17. INFORMANT ADDRESS<br><b>Thurston O. Thompkins--Same as 13c</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Shocks</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>12 hours.</b>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 10 1980</b> to <b>Nov 11 1980</b> , that (I) (we) last saw the deceased alive on <b>19</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Dr. Kelley mo.</b>   |  |   |  | DEGREE<br><b>ATTENDING PHYSICIAN</b> <input type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11/11/80.</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>David E Kelley</b>  |  |   |  | 22e. ADDRESS<br><b>University Hospital, 22 S. Greene St., Balto. MD.</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>   |  | 23b. DATE<br><b>11/12/1980</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount Crematory</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Walter Brooks Bradley Inc.,</b>  |  |   |  | ADDRESS<br><b>Balto Md. 21222</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 17 1980</b>  |  |
|   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Patricia K. Brady</b>  |  |  |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 27863

FOR  
1 - STATE  
REGISTRAR

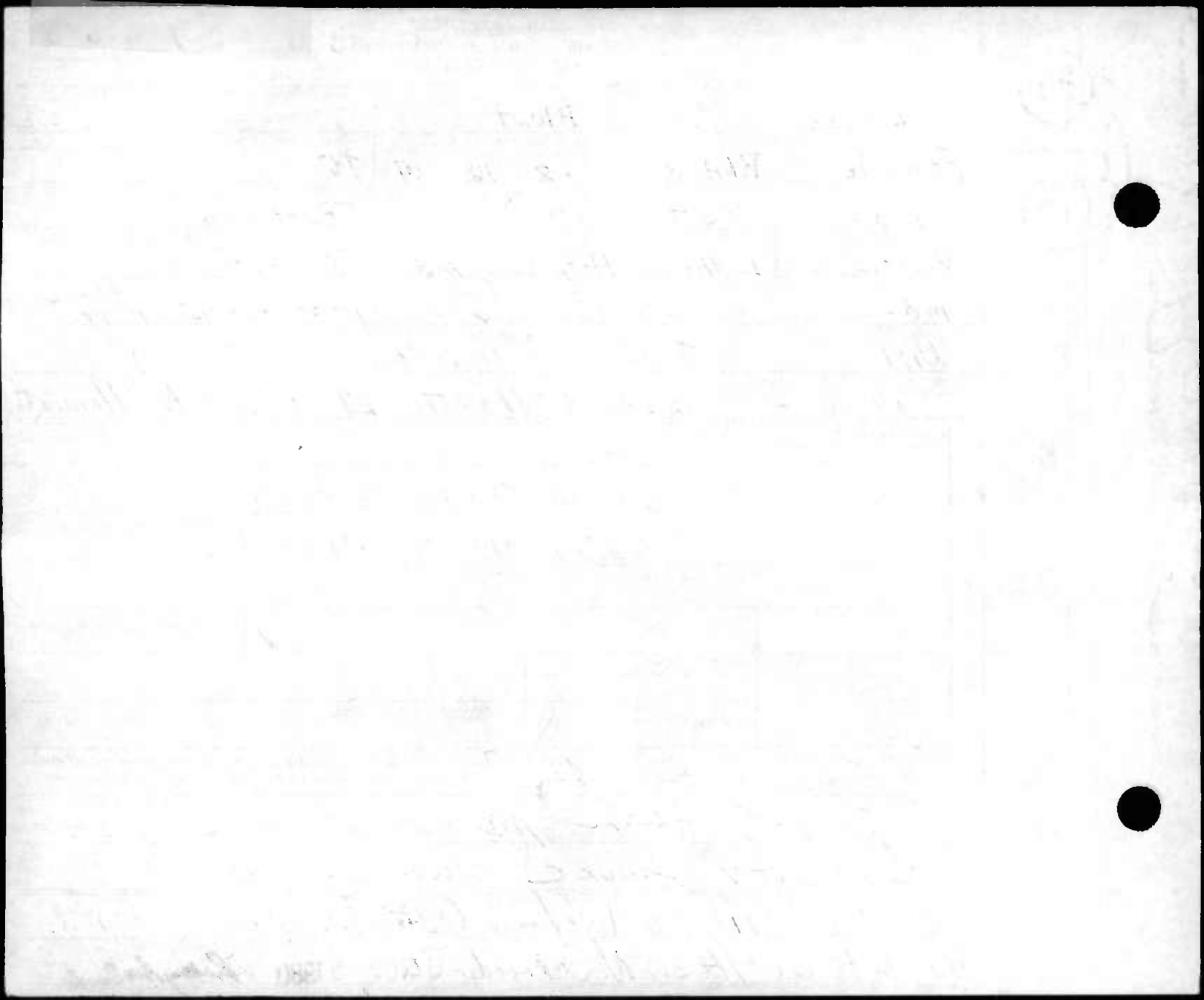
REG. NO.

|  |  |  |   |   |   |  |  |  |
|--|--|--|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Louise Blunt</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 2 80</b> |   | 2b. HOUR<br><b>5:30 AM</b>  |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Black</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 14 05</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS.  |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore</b> MD.   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Lutheran Hospital of Md.</b> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Domestic</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |
| 13a. STATE<br><b>md.</b>   |  | 13b. COUNTY<br><b>BALTO.</b>   |   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 13e. STREET ADDRESS<br><b>1737 N. Ellamont St.</b>   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Will Tiden</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Martha (Tiden)</b>   |   | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO -</b>  |   |  |  |  |
| 16a. SOCIAL SECURITY NO.<br><b>216-38-4477</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Matthew Blunt 1737 N. Ellamont</b>  |   |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CHF</b><br><b>4241</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>2° to Aortic Stenosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Calcification of Aortic Valve</b> |  |  |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from <b>10-17</b> , 19 <b>80</b> , to <b>11-2</b> , 19 <b>80</b> , that (we) lost<br>saw the deceased alive on <b>11-2</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (If (we) did not view the body after death.)   |  |  |   |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Sissat Awoke</b>  |  |  |   | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>11-2-80</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SISSAT Awoke</b>   |  |  |   | 22e. ADDRESS<br><b>Lutheran Hospital</b>  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>10/7/80</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Pinehawn Cemetery</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Annapolis Md.</b>   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Chas. H. Powell F/H</b>   |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 5 1980</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Robert H. [Signature]</b>   |  |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 27864

FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>George Joseph Boivin   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 8 1980  |  | 2b. HOUR<br>12:25 PM   |
| 3. SEX<br>Male  | 4. RACE<br>White   | 5. DATE OF BIRTH<br>March 14, 1920  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>60 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Mass.  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST AGNES HOSPITAL |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland  |  |   | 13b. CITY OR TOWN<br>Baltimore  |  |  |
| 13c. CITY OR TOWN<br>Arbutus  |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>late Emile Boivin   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>late   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WW 11  | 17. INFORMANT<br>ADDRESS<br>Mrs Mary Boivin Apt 216 Oaklee Village                              |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Hypokalemia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Carcinoma of pancreas → Intestinal obstruction</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 Weeks. |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (this hospital) attended the deceased from <u>Oct, 30,</u> 19 <u>80</u> , to <u>Nov, 8,</u> 19 <u>80</u> , that (we) last saw the deceased alive on <u>Nov, 8,</u> 19 <u>80</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (not) view the body after death.                         |  |   |   |  |  |
| 22b. SIGNATURE<br><u>P. Reddy</u>   |  | DEGREE<br><u>MD</u>   |   | 22c. DATE SIGNED<br><u>Nov, 8, 1980</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>DR. T. P. REDDY</u>   |  | 22e. ADDRESS<br><u>900 CATON AVE BALTIMORE MD 21229</u>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>  |  | 23b. DATE<br><u>Nov 11, 1980</u>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Meadowridge</u>                             |  |
| 23d. LOCATION<br>CITY OR TOWN<br><u>Howard, Maryland</u>  |  | 23e. STATE<br><u>Maryland</u>   |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Harry H Witzke</u>   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><u>NOV 10 1980</u>   |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>Jeffrey Hubbard</u>  |  |   |   |  |  |

THE UNIVERSITY OF CHICAGO  
LIBRARY

CHICAGO ILLINOIS

AT THE UNIVERSITY OF CHICAGO

CHICAGO ILLINOIS

CHICAGO ILLINOIS

CHICAGO ILLINOIS

CHICAGO ILLINOIS

CHICAGO ILLINOIS

CHICAGO ILLINOIS

CHICAGO ILLINOIS

CHICAGO ILLINOIS

CHICAGO ILLINOIS

CHICAGO ILLINOIS

CHICAGO ILLINOIS





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 7 8 6 5

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |   |   |   |
|---|---|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>William H. Bond</b>                        |   |   | 2a. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>30</b> YEAR <b>80</b>                       |   | 2b. HOUR <b>11:34</b> AM  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH <b>5</b> DAY <b>14</b> YEAR <b>05</b>   |   | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>75</b> YRS.                     |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>                           | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b> MD.          |   |
| 10. CITY OR TOWN OF DEATH<br><b>City</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Lutheran Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>      |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>  |
| 13a. STATE<br><b>MD.</b>  |   |   | 13b. COUNTY<br><b>Balt</b>  | 13c. CITY OR TOWN<br><b>Balto.</b>                                      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST <b>GEORGE</b> MIDDLE <b>WASH.</b> LAST <b>BOND</b>     |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>MARGARET</b> MIDDLE <b>BUSCH</b> LAST <b>BUSCH</b> |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b> |   | 16b. SOCIAL SECURITY NO.<br><b>005-09-9551</b>  |   | 17. INFORMANT<br>ADDRESS <b>5904</b><br><b>VIOLET BOND CHARNWOOD RD</b> |   |

## MEDICAL CERTIFICATION

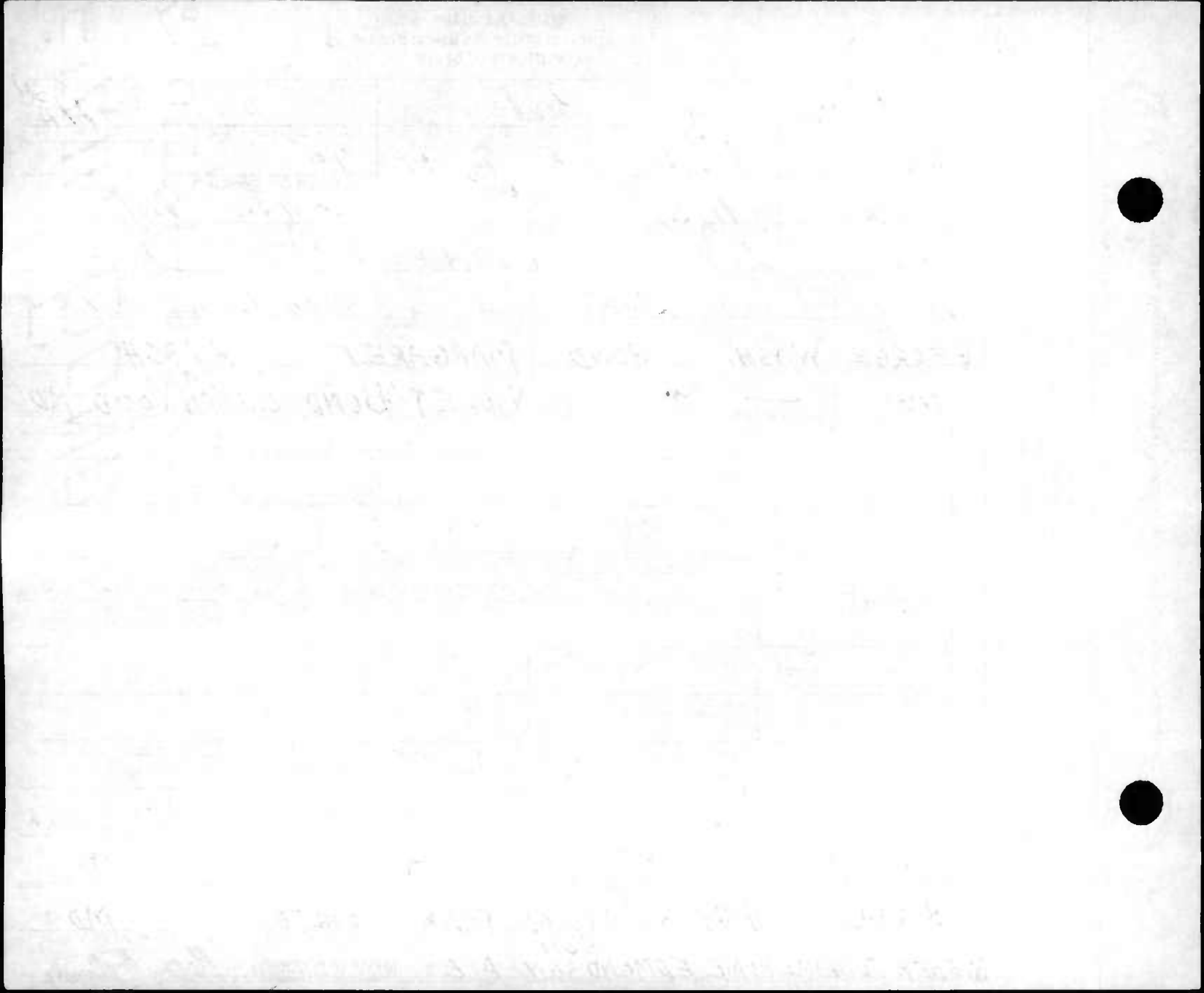
|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Cerebrovascular accident</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Suspect cerebral hemorrhage</b>              |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>Hypertensive atherosclerotic cardiovascular disease</b>  |  |  |  |   |  |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/20/80</b> to <b>11/20/80</b> , that (I) (we) lost<br>saw the deceased alive on <b>11/20/80</b> and that in (my/our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) did (did not) view the body after death. |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Kyaw Nyunt</b>   | DEGREE   |  |  | 22c. DATE SIGNED<br><b>11/20/80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KYAW NYUNT</b>  |  | 22e. ADDRESS<br><b>LUTHERAN HOSPITAL</b>                                       |  |   |  |

|   |                              |  |   |
|---|------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b> | 23b. DATE<br><b>11-24-80</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LODDON PARK</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO MD</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>WEBER FUNERAL HOME</b>     |                              | ADDRESS<br><b>EDMOND ST N AVE</b>                        | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 26 1980</b>           |
|   |                              | 25b. REGISTRAR'S SIGNATURE<br><b>P. J. Kelly</b>         |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 7 8 6 6

|  |   |   |  |
|--|---|---|--|
| 1. FOR STATE REGISTRAR   |   | REG. NO.  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>EARL A BONSEIGNEUR</b>  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 8, 1980</b><br>2b. HOUR<br><b>9:05 A.M.</b>  |  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>Cauc.</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 29 1896</b>  |  |
| 6a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b><br>IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Church Hospital</b> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Railroad</b>  | 12b. KIND OF BUSINESS OR INDUSTRY   |   |  |
| 13a. STATE<br><b>Md.</b>   | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  | 16b. SOCIAL SECURITY NO.  | 17. INFORMANT<br>ADDRESS<br><b>Catherine Bon Seigneur 2800 Jefferson</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>PROBABLE LUNG CANCER</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>CONGESTIVE HEART FAILURE</b>  |   |   |  |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) <u>this hospital</u> attended the deceased from <b>NOVEMBER 4, 1980</b> , to <b>NOVEMBER 8, 1980</b> , that (I) <u>was</u> lost<br>saw the deceased alive on <b>NOVEMBER 8, 1980</b> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated<br>above, (I) <u>we</u> (did) (did not) view the body after death.             |   |   |  |
| 22b. SIGNATURE<br><b>Winston Hugh Williams</b>   | DEGREE<br><b>M.D.</b>   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. ADDRESS<br><b>St. Charles Hospital Corporation, 100 N. Broadway, Baltimore, Maryland 21231</b>                        |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Winston Hugh Williams</b>  | 22e. ADDRESS<br><b>St. Charles Hospital Corporation, 100 N. Broadway, Baltimore, Maryland 21231</b>                                 |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>11/11/80</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cem.</b>   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>B. Dabrowski &amp; Son 2818 E. Baltimore St</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 12 1980</b>   | 25b. REGISTRAR'S SIGNATURE<br><b>Barbara A. Brady</b>  |

NOV 19 1988

NOV 19 1988

x

NOV 19 1988

NOV 19 1988

NOV 19 1988

x

NOV 19 1988

NOV 19 1988

NOV 19 1988

NOV 19 1988

NOV 19 1988

NOV 19 1988



NOV 19 1988

x

NOV 19 1988

NOV 19 1988

NOV 19 1988

NOV 19 1988

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |  |  |  |  |  |  | 8 0 2 7 8 6 7   |  |
|--|--|--|--|--|--|--|--|--|--|---|--|
| 1 - FOR STATE REGISTRAR  |  |  |  |  |  |  |  |  |  | CERTIFICATE OF DEATH  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH   |  |
| FIRST MIDDLE LAST  |  |  |  |  |  |  |  |  |  | MONTH DAY YEAR  |  |
| GRAY HERMAN BOOKER   |  |  |  |  |  |  |  |  |  | 11 15 80  |  |
| 3. SEX   |  |  |  |  |  |  |  |  |  | 7b. HOUR  |  |
| MALE   |  |  |  |  |  |  |  |  |  | 2:00P M   |  |
| 4. RACE  |  |  |  |  |  |  |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  |
| W  |  |  |  |  |  |  |  |  |  | 77  |  |
| 5. DATE OF BIRTH   |  |  |  |  |  |  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |  |
| MONTH DAY YEAR   |  |  |  |  |  |  |  |  |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                    |  |
| 6 22 03  |  |  |  |  |  |  |  |  |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |  |  |  |  |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |
| MARYLAND   |  |  |  |  |  |  |  |  |  | Baltimore City MD.  |  |
| 7b. CITIZEN OF WHAT COUNTRY?   |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                         |  |
| U.S.A.   |  |  |  |  |  |  |  |  |  | AIRCRAFT  |  |
| 10. CITY OR TOWN OF DEATH  |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| BALTIMORE  |  |  |  |  |  |  |  |  |  |   |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)   |  |  |  |  |  |  |  |  |  |   |  |
| VETERANS ADMINISTRATION MEDICAL CENTER   |  |  |  |  |  |  |  |  |  |   |  |
| 13a. STATE   |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS?  |  |
| MARYLAND   |  |  |  |  |  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                   |  |
| 13b. COUNTY  |  |  |  |  |  |  |  |  |  | 13e. STREET ADDRESS   |  |
| BALTIMORE  |  |  |  |  |  |  |  |  |  | 1545 Becklow Avenue   |  |
| 13c. CITY OR TOWN  |  |  |  |  |  |  |  |  |  |   |  |
| MIDDLE RIVER   |  |  |  |  |  |  |  |  |  |   |  |
| 14. FATHER'S NAME  |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME  |  |
| FIRST MIDDLE LAST  |  |  |  |  |  |  |  |  |  | FIRST MIDDLE LAST   |  |
| HENRY M. BOOKER  |  |  |  |  |  |  |  |  |  | RUTH LOVETT   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  |  |  |  |  |  |  | 17. INFORMANT ADDRESS   |  |
| YES  |  |  |  |  |  |  |  |  |  | VAMC Clinical Records Balto., Md. 21218   |  |
| 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)   |  |  |  |  |  |  |  |  |  |   |  |
| WW 2 577 20 3807   |  |  |  |  |  |  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 1. DEATH WAS CAUSED BY:   |  |  |  |  |  |  |  |  |  |   |  |
| IMMEDIATE CAUSE (a) <u>cardiac arrest - pulmonary arrest</u>   |  |  |  |  |  |  |  |  |  | 5 min   |  |
| 5789   |  |  |  |  |  |  |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.   |  |  |  |  |  |  |  |  |  |   |  |
| (b) <u>big heart, debilitated</u>  |  |  |  |  |  |  |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  |   |  |
| (c)  |  |  |  |  |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                |  |  |  |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |  |  |  |  |  |  |  |  | 20a. AUTOPSY?   |  |
|  |  |  |  |  |  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                   |  |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?                        |  |
|  |  |  |  |  |  |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)        |  |
| 21b. TIME OF INJURY  |  |  |  |  |  |  |  |  |  |   |  |
| HOUR A.M. MONTH DAY YEAR   |  |  |  |  |  |  |  |  |  |   |  |
| P.M. 19  |  |  |  |  |  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED   |  |  |  |  |  |  |  |  |  | 21f. LOCATION   |  |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  |  |  |  |  |  |  |  | STREET CITY OR TOWN COUNTY STATE  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from   |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED  |  |
| OCTOBER 28, 19 80, to NOVEMBER 15, 19 80, that (I) (we) lost   |  |  |  |  |  |  |  |  |  | 12/14/80  |  |
| saw the deceased alive on  |  |  |  |  |  |  |  |  |  |   |  |
| above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |  |  |  |  |   |  |
| 22b. SIGNATURE   |  |  |  |  |  |  |  |  |  | 22e. ADDRESS  |  |
| R. J. Davis, M.D.  |  |  |  |  |  |  |  |  |  | 3900 Loch Raven Blvd. Balto., Md. 21218   |  |
| DEGREE   |  |  |  |  |  |  |  |  |  |   |  |
| ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>         |  |  |  |  |  |  |  |  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  |  |  |  |  |  |  |   |  |
| R. J. Davis, M.D.  |  |  |  |  |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  |  |  |  |  |  |  |  | 23b. DATE   |  |
| BURIAL   |  |  |  |  |  |  |  |  |  | 11/18/80  |  |
| 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  |  |  |  |  |  |  | 23d. LOCATION   |  |
| GARDENS OF FAITH   |  |  |  |  |  |  |  |  |  | BALTO MD.   |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR   |  |
| NAME ADDRESS   |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE  |  |
| J. G. CONNELLY 300 MACE  |  |  |  |  |  |  |  |  |  | NOV 20 1980   |  |



NOV 20 1980  
U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535  
TO : DIRECTOR, FBI  
FROM : SAC, NEW YORK  
SUBJECT: [Illegible]  
RE: [Illegible]

[Large section of illegible text, likely a memorandum or report body]

NOV 20 1980  
U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535  
[Illegible text at the bottom of the page]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

|   |         |  |  |   |  |   |  |                                |  |                                |  |                   |   |
|---|---------|--|--|---|--|---|--|--------------------------------|--|--------------------------------|--|-------------------|---|
| 1 DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST  |  | MIDDLE  |  | LAST  |  | 2a. DATE KNOWN<br>OF DEATH     |  | ESTIMATED<br>MONTH DAY YEAR    |  | 2b. HOUR<br>M     |   |
| DONALD  |         | BOONE  |  |   |  |   |  | 11-20-80                       |  |                                |  | 4:24 P M          |   |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH<br>MONTH DAY YEAR   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY  |  | IF UNDER 1 YR.<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN. |  | 7c. DATE<br>PRONOUNCED<br>DEAD |  | 8. MONTH DAY YEAR |   |
| male  | black   | 9 25 33  |  | 47 YRS.   |  |   |  |                                |  | 11-20-80                       |  |                   |   |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |                                |  |                                |  |                   |   |
| Md.   |         | U. S. A.   |  |   |  | Baltimore City  |  |                                |  |                                |  |                   |   |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY  |  |                                |  |                                |  |                   |   |
| Baltimore   |         | Lutheran Hospital  |  |   |  |   |  |                                |  |                                |  |                   |   |
| 13a. STATE  |         | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS            |  |                                |  |                   |   |
| Md.   |         |  |  | Baltimore   |  |   |  | 3607 N. Rogers Ave.            |  |                                |  |                   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST  |  |   |  |   |  |                                |  |                                |  |                   |   |
| Frank   |         | Edna   |  | Boone   |  |   |  |                                |  |                                |  |                   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)   |         | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)  |  | 17. INFORMANT   |  | ADDRESS   |  |                                |  |                                |  |                   |   |
| Yes   |         | 213-26-8256  |  | Ruby L. Boone   |  | 3607 N. Rogers Ave.   |  |                                |  |                                |  |                   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |         |  |  |   |  |   |  |                                |  |                                |  |                   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |         |  |  |   |  |   |  |                                |  |                                |  |                   |   |
| 19a. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |                                |  |                                |  |                   |   |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |                                |  |                                |  |                   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |         | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |                                |  |                                |  |                   |   |
| 22a. I certify that I took charge of the remains described above, held on <u>Autopsy</u> <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |  |  |   |  |   |  |                                |  |                                |  |                   |   |
| ACTUAL<br>SIGNATURE   |         | TITLE (SPECIFY)<br>M.D. Assistant  |  | MEDICAL EXAMINER  |  | DATE<br>SIGNED  |  | 11-21-80                       |  |                                |  |                   |   |
| EXAMINER'S NAME<br>(TYPE OR PRINT)  |         | Margarita A. Korell, M.D.  |  | ADDRESS   |  | 111 Penn Street   |  |                                |  |                                |  |                   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |                                |  |                                |  |                   |   |
| Burial  |         | 11/25/80   |  | Crownsville VA Cemetery   |  | Crownsville, Md.  |  |                                |  |                                |  |                   |   |
| 24. FUNERAL DIRECTOR<br>NAME  |         | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |                                |  |                                |  |                   |   |
| Wm. C. March F/H Inc.   |         | 1101 E. North Ave.   |  | NOV 25 1980   |  | F. J. H. H. H.  |  |                                |  |                                |  |                   |   |



*Handwritten signature or initials.*

0001 2 8 VOM



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

2 7 8 6 9

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |  |  |  |   |  |   |  |
|---|--|--|---|--|--|--|---|--|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>Nellie V. Bowers</b>   |  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>11-25-80</b>                                       |  |  | 2b HOUR<br><b>5:30AM</b>   |   |  |   |  |
| 3 SEX<br><b>Female</b>  |  | 4 RACE<br><b>White</b>   |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 15, 1890</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>90</b>  |   | 7 IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS.</b>   |   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balto., Md.</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |   |  |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore,</b>   |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>Jenkins Memorial Home</b><br>1000 S. Caton Ave. Balt. Md. 21229 |   |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>                          |   | 12b KIND OF BUSINESS OR INDUSTRY<br><b>----</b>  |   |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>   |  |  | 13b. COUNTY<br><b>----</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>305 Marydell Road</b>           |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Bright</b>   |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Clara ?</b>                              |  |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b> |   |  |   |  |
| 16b SOCIAL SECURITY NO.<br><b>214-74-0775</b>   |  |  | 17 INFORMANT<br><b>Mr. Clifton L. Bowers-238 Gralan Rd.</b><br>Catonsville, Maryland, 21229 |  |  |  |   |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1: DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>yr</b> |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Arteriosclerotic cerebrovascular disease</b>   |  |  |   |  |  |  |   |  |   |  |
| 19a DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                    |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)     |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                      |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                  |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-28</b> , 19 <b>25</b> , to <b>11-25</b> , 19 <b>80</b> , that (he) (we) lost<br>saw the deceased alive on <b>11-25</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death.                 |  |  |   |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Laurens R. Gallager MD</b>   |  |  |   |  | DEGREE<br><b>MD</b>  |  |   | 22c. DATE SIGNED<br><b>11-25-80</b>  |   |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>L. GALLAGER MD</b>  |  |  |   |  | 22e. ADDRESS<br><b>STAGNES MED CTR 21229</b>                                       |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>11/28/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery - Baltimore, Md.</b> |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Sterling Funeral Estate</b><br>736 Edmondson Ave.<br>Catonsville, Md. 21228  |  |  |   |  | 25a. DATE RECEIVED BY REGISTRAR<br><b>DEC 1 1980</b>                               |  | 25b. <b>Handwritten signature</b>   |  |   |  |



Handwritten text, mostly illegible due to blurring and bleed-through. Visible fragments include:  
- "Baltimore" (appearing multiple times)  
- "John" (appearing multiple times)  
- "11, 1900" (at the bottom)  
- "1881" (at the bottom)  
- "11, 1900" (at the bottom)  
- "1881" (at the bottom)  
- "11, 1900" (at the bottom)  
- "1881" (at the bottom)

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 7 8 7 0

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |                              |  |  |
|--|--|--|--|---|------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>VERNON A. BOWERS</b>   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>11 4 80</b> |   | 2b. HOUR<br><b>1:40 A.M.</b> |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Aug. 7, 1911</b>  |                              | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS<br><b>69</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |                              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST AGNES HOSPITAL</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Chemist</b>   |                              | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Retired</b>  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Anne Arundel</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |                              | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Albert F. Bowers</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Mabel Wilson</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR AND DATES)<br><b>Yes WW II</b>  |                              | 16b. SOCIAL SECURITY NO.<br><b>215-01-5495</b>   |  |
| 17. INFORMANT<br><b>Mrs. Etta Bowers</b>   |  | ADDRESS<br><b>Same as #13</b>  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Artery</b><br><b>4960</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Respiratory failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Chronic obstructive pulmonary disease</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 day</b> |                              | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                              | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                              | 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                               |  |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  | 22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 3, 1980</b> , to <b>Nov 4, 1980</b> , that (I) (we) lost saw the deceased alive on <b>Nov 3, 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |                              | 22b. SIGNATURE<br><b>T. P. Reddy</b>   |  |
| 22c. DATE SIGNED<br><b>Nov 4, 1980</b>   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR REDDY</b>   |  | 22e. ADDRESS<br><b>St. Agnes Hospital</b>   |                              | 22f. DEGREE<br><b>MD</b>   |  |
| 22g. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>11/7/1980</b>   |                              | 23c. NAME OF CEMETERY OR CREMATORY<br><b>London Park Cemetery</b>  |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>  |  | 23e. NAME OF FUNERAL DIRECTOR<br><b>McGully Funeral Home</b>   |  | 23f. ADDRESS<br><b>Balt., Md., 21225 237 E. Patapsco Ave.</b>   |                              | 23g. DATE REC'D. BY REGISTRAR<br><b>NOV 5 1980</b>   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



BALTIMORE CITY

ST. JOSEPH HOSPITAL

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 7 8 7 1

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|   |   |   |  |  |  |
|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Beatrice A. Bowles  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 18 80                  |  | 2b. HOUR<br>11:55 AM   |
| 3. SEX<br>F   | 4. RACE<br>B  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 27 04   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>76 YRS.                       |  | 7. UNDER 1 YEAR<br>MONTHS DAYS<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Va.  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                           |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>609 Lynhurst St. |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br>Md.   |   |   | 13b. COUNTY<br>Balto.  | 13c. CITY OR TOWN<br>Baltimore   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charlie Johnson   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Maggie Williams |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>220-30-1467  |  | 17. INFORMANT<br>ADDRESS<br>Alton W. Bowles 609 Lynhurst St.                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrhythmia</u><br>4140<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Arteriosclerotic Heart Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>10 years</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>10-15 min.   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |   |   |  |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/29/74</u> , 19 <u>80</u> , to <u>11/18</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>10/31</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                     |   |   |  |  |  |
| 22b. SIGNATURE<br><u>Roland T. Smoot, M.D.</u>  |   |   | DEGREE<br>M.D.   |  | 22c. DATE SIGNED<br>11/19/80   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ROLAND T. SMOOT, M.D.  |   |   | 22e. ADDRESS<br>2300 GARRISON BLVD, BALTO, MD.                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |   | 23b. DATE<br>11/22/80   | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Mem. Pk.           |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Arbutus, Md.   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm C March F/H  |   |   | ADDRESS<br>1101 E. North Ave.                                    |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 21 1980   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please detach for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 27872

FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |   |  |   |                                   |  |  |
|--|--|---|---|---|--|---|-----------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>James Bowser</i>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>11/3/80</i>                 |   | 2b. HOUR<br>MIN<br><i>4<sup>10</sup> PM</i>                      |   |                                   |  |  |
| 3. SEX<br><i>Male</i>  |  | 4. RACE<br><i>Black</i>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>10 10 21</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YEARS MONTHS DAYS<br><i>57</i>   |                                   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>North Carolina</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City MD.</i>   |                                   |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Bon Secours Hosp.</i> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |   | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| 13a. STATE<br><i>md.</i>   |  | 13b. COUNTY   |   | 13c. CITY OR TOWN<br><i>Baltimore</i>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |                                   | 13e. STREET ADDRESS<br><i>2541 W. Baltimore St</i> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Rassiter Lester</i>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Jessie Bowser</i> |   |  |   |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>240-20-8885</i>   |   | 17. INFORMANT<br>ADDRESS<br><i>K. Bacon - Bon Secours</i>   |  |   |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Possible acute Myocardial Infarction</i><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Arteriosclerotic Cardiovascular Disease</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><i>Coronary Arrhythmia, Congestive Heart Failure</i> |  |   |   |   |  |   |                                   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH    |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |                                   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |                                   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>11/16/78</i> to <i>11/3/80</i> , that (I) (we) lost<br>saw the deceased alive on <i>11/29/80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |  |   |                                   |  |  |
| 22b. SIGNATURE<br><i>Rifat Aboumy</i>  |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED  |                                   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Rifat Aboumy</i>   |  |   |   | 22e. ADDRESS<br><i>2300 Garrison Blvd</i>   |  |   |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>  |  | 23b. DATE<br><i>11-6-80</i>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Balto Cemetery</i>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Balto City</i>   |                                   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Theodore D Voag</i>   |  |   |   | ADDRESS<br><i>2527 Bay Ave</i>  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>NOV 5 1980</i>  |                                   | 25b. REGISTRAR'S NAME<br><i>Rifat Aboumy</i>       |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



0851 6



10  
1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 7 8 7 3

REG. NO.

|   |                     |  |  |   |                           |
|---|---------------------|--|--|---|---------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ELIZABETH M. BOYD</b>                          |                     |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11-25-80</b> |   | 2b. HOUR<br>M<br><b>M</b> |
| 3. SEX<br><b>F</b>  | 4. RACE<br><b>W</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8-13-1911</b> |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS<br><b>69</b>   |                           |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                          |                     | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>          |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                           |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE, CTY</b>                         |                     | 10. CITY OR TOWN OF DEATH<br><b>BALTO.</b>             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2413 McELDERRY ST.</b>                      |                           |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SEAMSTRESS</b> |                     | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>TAILORING</b>  |  |   |                           |

|   |  |   |  |  |   |  |
|---|--|---|--|--|---|--|
| 13a. STATE<br><b>MD.</b>  |  |   | 13b. COUNTY<br><b>—</b>  | 13c. CITY OR TOWN<br><b>BALTO.</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>2413 McELDERRY ST.</b> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOHN G. BREITENBACH</b>              |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARGARET KIRBY</b> |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b> |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>215-01-6094</b> |  | 17. INFORMANT<br>ADDRESS<br><b>Mr. Howard A. Boyd, Jr. - 4307 GREENHILL AVE.</b> |   |  |

|   |  |   |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Ventricular Fibrillation</b><br><b>4019</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Hypertension</b><br>(c) <b>Generalized Atherosclerosis</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2-77</b> |
|---|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):  
**none**

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 19a. DATE OF OPERATION<br><b>—</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>—</b>           |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-16-77</b> , 19 <b>80</b> , to <b>10-1</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>10-1</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |
| 22b. SIGNATURE<br><b>[Signature]</b>  |  | DEGREE   |  | 22c. DATE SIGNED<br><b>11-26-80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>George A. Adoniz-Smith MD.</b>  |  | 22e. ADDRESS<br><b>2601 E. Monument St</b>                             |  |  |  |

|  |                              |  |  |
|--|------------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                         | 23b. DATE<br><b>11-29-80</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>OAK LAWN Cem.</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO., MD.</b> |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Garter, Miller - 2334 Jefferson St.</b> |                              |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV. 26 1980</b>             |
|  |                              |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                 |

RECEIVED



RECEIVED

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

2 7 8 7 4

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |   |   |   |  |  |
|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>JOHN E BOYLE   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>NOVEMBER 23, 1980  |  | 2b. HOUR<br>8:34PM   |
| 3 SEX<br>MALE  | 4. RACE<br>WHITE  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>MAR. 5, 1947  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>33   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>NEW YORK  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                     |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>JOHNS HOPKINS HOSPITAL |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>V-PRES. MARKETING           |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>RETAIL INDUSTRY             |
| 13a. STATE<br>NEW YORK   | 13b. COUNTY<br>MONROE   | 13c. CITY OR TOWN<br>HENRIETTA  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br>149 QUINN RD.   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>WILLIAM F. BOYLE   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>FLORENCE DOWD  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>N/A  | 17. INFORMANT<br>DAVID P. WARNER<br>ADDRESS<br>673 W. GREENBELT PARKWAY<br>HOLBROOK, LONG ISLAND<br>N.Y. 11749  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIO VASCULAR COLLAPSE</u><br>0389<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>PRESUMED SEPSIS</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>36 hours<br>48 hours |   |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>CYTOMEGALOVIRUS INFECTION</u>   |   |   |   |  |  |
| 19a. DATE OF OPERATION<br>10-23-80   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>PERIRECTAL ABSCESS  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |   |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11-1</u> , 19 <u>80</u> , to <u>11-23</u> , 19 <u>80</u> , that (I) (we) lost<br>saw the deceased alive on <u>11-23</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |   |   |   |  |  |
| 22b. SIGNATURE<br>Mary M Newman  |   | DEGREE<br>MD  |   | 22c. DATE SIGNED<br>11-23-80   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MARY M NEWMAN   |   | 22e. ADDRESS<br>(5) JOHNS HOPKINS HOSPITAL  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |   | 23b. DATE<br>11/26/80   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>HOLY SEPULCHRE                           |  |
| 23d. LOCATION<br>CITY OR TOWN<br>ROCHESTER   |   | COUNTY<br>MONROE  |   | STATE<br>N.Y.  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>E. BARNES FLEMING<br>FUNERAL SERVICE   |   | ADDRESS<br>21018<br>BENSON, MD.   |   | 25a. DATE REC'D. BY REGISTRAR<br>DEC 1 1980                                    |  |

69  
33  
69  
736  
3  
1  
2  
1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_



25  
P81  
1017E ADH 1  
1017E ADH 1

8  
C2100

171

*[Faint, mostly illegible text and markings covering the main body of the page, possibly bleed-through from the reverse side.]*

(030)



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

80 27875

1- FOR  
STATE  
REGISTRAR

|   |   |   |   |  |  |
|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>RUBY WITHERSPOON DIXON BRANCH   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>NOVEMBER 12, 1980  |  | 2b. HOUR<br>11:47P   |
| 3. SEX<br>Female  | 4. RACE<br>Negro  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 12 27  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>52<br>YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>N.C.   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY                                |
| 13a. STATE<br>MD  | 13b. COUNTY<br>H A.   | 13c. CITY OR TOWN<br>Baltimore  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>134-26 156th St.  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Leonard Witherspoon   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Madgline Basinger  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |   | 16b. SOCIAL SECURITY NO.<br>245-34-3740   |   | 17. INFORMANT<br>ADDRESS<br>Carolyn Dixon 814 Nat. Ct.                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>hypotension &amp; lactic acidosis</u><br>3570<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>septic shock /</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Ciullam Bone syndrome</u> |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                     |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>11:46P.M. 11 12 1980   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/30</u> , 19 <u>80</u> , to <u>11/12</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>11/12</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |   |   |   |  |  |
| 22b. SIGNATURE<br><i>John Mannisi</i>   |   | DEGREE<br>M.D.  |   | 22c. DATE SIGNED<br>11/12/80   |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br>John Mannisi   |   | 22e. ADDRESS<br>601 N. Broadway Balt. MD 21205  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |   | 23b. DATE<br>11/17/80   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Oakwood Cem.                                   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Salisbury N.C.  |   | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Wm. C. March F/H 1101 E. North Ave.   |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 14 1980   |  |
|   |   | 25b. REGISTRAR'S SIGNATURE<br><i>Patsy Melby</i>  |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BRANCH, RUBY  
194 21 41



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1 - STATE REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 7 8 7 6

REG. NO.

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>WINSTON BRANHAM</b>   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>NOVEMBER 4, 1980</b>  |  | 2b. HOUR<br>M   |  |
| 3 SEX<br><b>MALE</b>   |  | 4 RACE<br><b>WHITE</b>   |  | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>Nov 3, 1909</b>                              |  |
| 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS.   |  | 7. IF UNDER 1 YEAR MONTHS DAYS   |  | 8. IF UNDER 24 HRS. HOURS MIN.  |  |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   |  | 9b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 9c. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>HOME = 1303 N. Calvert St.</b>          |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Laborer</b>   |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Cemetery</b>   |  | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE<br><b>Md.</b>                                |  | 13b. COUNTY   |  |
| 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>1303 N. Calvert St.</b>                                 |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><b>PI DGE BRANHAM</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>RENA HAMILTON</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>231 12 2792</b>   |  | 17 INFORMANT ADDRESS<br><b>Gertrude Branham same as 13 e</b>                      |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic adenocarcinoma prostate</b><br><b>1850</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Emphysema</b>  |  |  |  |   |  |
| 19a. DATE OF OPERATION<br><b>10/8</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/8</b> 19 <b>80</b> , to <b>10/31</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive <b>10/31/80</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Jeffrey H. Pargament</b>  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11/5/80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Jeffrey Pargament</b>  |  | 22e. ADDRESS<br><b>9518 Philadelphia Rd.</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>11/7/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem Pk</b>                    |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Glen Burnie A.A. Md.</b>   |  |  |  |   |  |
| 24 FUNERAL DIRECTOR NAME<br><b>George J. Gonce</b>   |  | ADDRESS<br><b>4001 Ritchie Hgwy.</b>   |  | 25a. DATE RECEIVED BY REGISTRAR<br><b>NOV 10 1980</b>                             |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Jeffrey H. Pargament</b>  |  |  |  |   |  |

0501 4 NOVEMBER 1950

21

0001 1950

11/10/50

11/10/50

11/10/50

11/10/50

11/10/50

11/10/50

11/10/50

11/10/50



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |  |  |  |  |  |  |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>DORIS H. BRENDENL  |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>11 5 80  |  |  |  |  |
| 3 SEX<br>Female   |  |  |  |  | 4 RACE<br>White  |  |  |  |  |
| 5 DATE OF BIRTH MONTH DAY YEAR<br>1 8 1919  |  |  |  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>61 YRS   |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  |  |  |
| 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |  |  |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD   |  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>BALTIMORE   |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Agnes Hospital |  |  |  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>CLERK  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>DEPT. STORE   |  |  |  |  |
| 13a. STATE<br>MARYLAND  |  |  |  |  | 13b. COUNTY<br>BALTIMORE   |  |  |  |  |
| 13c. CITY OR TOWN<br>BALTO. HGLDS.  |  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                              |  |  |  |  |
| 13e. STREET ADDRESS<br>3036 NEW YORK AVENUE, 21227  |  |  |  |  |  |  |  |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>JOHN J. ARNOLD  |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>EMMA V. THOMAS   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO   |  |  |  |  | 16b. SOCIAL SECURITY NO.<br>220-22-2923  |  |  |  |  |
| 17 INFORMANT ADDRESS<br>JOAN D. MARSIGLIA 3036 NEW YORK AVENUE  |  |  |  |  |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest.</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Massive Myocardial Infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Sudden</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  |  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  |  |  |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on <u>Oct 3</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Justinas Kudirka</u>   |  |  |  |  | 22c. DATE SIGNED<br>11-5-80  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JUSTINAS KUDIRKA, M.D.   |  |  |  |  | 22e. ADDRESS<br>3427 Annapolis Rd.   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  |  |  |  | 23b. DATE<br>11-08-80  |  |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>LOUDON PARK   |  |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>BALTIMORE CITY MARYLAND   |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>HUBBARD FUNERAL HOME, INC.   |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 6 1980  |  |  |  |  |
| 25b. ADDRESS<br>4107 WILKENS AVE.   |  |  |  |  | 25c. REGISTRAR'S SIGNATURE<br><u>Anthony K. Kelly</u>  |  |  |  |  |

BP  
DHMH-16 25M  
(VRA 15, 4) 1/79

4301

MEMORANDUM

DATE

TO :

FROM :

SUBJECT :

RE :

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 2 7 3 7 8  
CERTIFICATE OF DEATH

|   |  |  |   |   |                                    |  |   |  |                            |   |  |
|---|--|--|---|---|------------------------------------|--|---|--|----------------------------|---|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO.   |   |   |                                    |  |   |  |                            |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |   |   | 2a. DATE OF DEATH                  |  |   |  |                            | 2b. HOUR  |  |
| FIRST MIDDLE LAST<br>Julian F Bright  |  |  |   |   | MONTH DAY YEAR<br>11/20/80         |  |   |  |                            | 7:40 AM   |  |
| 3. SEX  |  | 4. RACE  |   | 5. DATE OF BIRTH  |                                    |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  |                            | IF UNDER 1 YEAR<br>IF UNDER 24 HRS                            |  |
| M   |  | B  |   | MONTH DAY YEAR<br>7 4 23  |                                    |  | 57 YRS.   |  |                            | MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                            |   |  |
| Baltimore City  |  | USA  |   |   |                                    |  | Baltimore City MD.  |  |                            |   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |   |                                    |  |   |  |                            | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  |
| Baltimore, City   |  | U. of Md. Hosp.  |   |   |                                    |  |   |  |                            |   |  |
| 13a. STATE  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN   |                                    |  | 13d. INSIDE CITY LIMITS?  |  |                            | 13e. STREET ADDRESS   |  |
| Md.   |  |  |   | Baltimore City  |                                    |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                            | 1907 N. Eutaw Pl.   |  |
| 14. FATHER'S NAME   |  |  |   | 15. MOTHER'S MAIDEN NAME  |                                    |  |   | ADDRESS  |                            |   |  |
| FIRST MIDDLE LAST<br>Percy Bright   |  |  |   | FIRST MIDDLE LAST<br>Louise Bousser   |                                    |  |   |  |                            |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT   |                                    |  | ADDRESS   |  |                            |   |  |
| Yes   |  | 216-14-0782  |   | SHIRLEY BRIGHT  |                                    |  | 1907 Eutaw Place Apt. C2  |  |                            |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u><br><br>4149<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Heart failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Renal failure</u>                                      |  |  |   |   |                                    |  |   |  |                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                  |  |
|   |  |  |   |   |                                    |  |   |  |                            | 10 mins.  |  |
|   |  |  |   |   |                                    |  |   |  |                            | 4 months  |  |
|   |  |  |   |   |                                    |  |   |  |                            | 2 months  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>abdominal aneurysm</u>   |  |  |   |   |                                    |  |   |  |                            |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |                                    | 20a. AUTOPSY?  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                            |   |  |
| 7/80  |  |  | Coronary Artery Disease   |   |                                    | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                            |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY   |   |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |                            |   |  |
|   |  |  | HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                 |   |                                    |  |   |  |                            |   |  |
| 21d. INJURY OCCURRED  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |                                    | 21f. LOCATION  |   |  | CITY OR TOWN COUNTY STATE  |   |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |   |   |                                    | STREET   |   |  |                            |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/5</u> , 19 <u>80</u> , to <u>11/20</u> , 19 <u>80</u> , that (II) (we) lost <u>11/19</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |   |                                    |  |   |  |                            |   |  |
| 22b. SIGNATURE  |  |  |   |   |                                    | DEGREE   |   |  | 22c. DATE SIGNED           |   |  |
| Jan Laws Houghton   |  |  |   |   |                                    | MD   |   |  | 11/20/80                   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |   |   |                                    | 22e. ADDRESS   |   |  |                            |   |  |
| Jan Laws Houghton MD  |  |  |   |   |                                    | U. of Md. Hosp.  |   |  |                            |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY |  |   | 23d. LOCATION  |                            |   |  |
| Burial  |  |  | 11/25/80  |   | Mt. Auburn Cemetery                |  |   | Baltimore, COUNTY STATE<br>Md.                                 |                            |   |  |
| 24. FUNERAL DIRECTOR  |  |  |   |   |                                    | 25a. DATE REC'D. BY REGISTRAR  |   |  | 25b. REGISTRAR'S SIGNATURE |   |  |
| NAME ADDRESS<br>Wm. C. March F/H Inc. 1101 E. North Ave.  |  |  |   |   |                                    | NOV 25 1980  |   |  | [Signature]                |   |  |

0821 C 5 YUM

2 7 8 7 9

|  |                                  |                                    |                               |        |          |
|--|----------------------------------|------------------------------------|-------------------------------|--------|----------|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) | 23b. DATE                        | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION<br>CITY OR TOWN | COUNTY | STATE    |
| BURIAL                                       | 11-15-80                         | Cedar Hill Cemetery                | Bethesda                      |        | Maryland |
| 24. FUNERAL DIRECTOR<br>NAME                 | 25a. DATE REC'D. BY REGISTRAR    |                                    | 25b. REGISTRAR'S SIGNATURE    |        |          |
| Charles L. Stevens Funeral Home, Inc.        | 1501 E. Fort Ave.<br>NOV 14 1980 |                                    | Lester A. Roberts             |        |          |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

DHMH-17  
(VR A15 ME (5))  
15A 2/80

NOV 14 1980



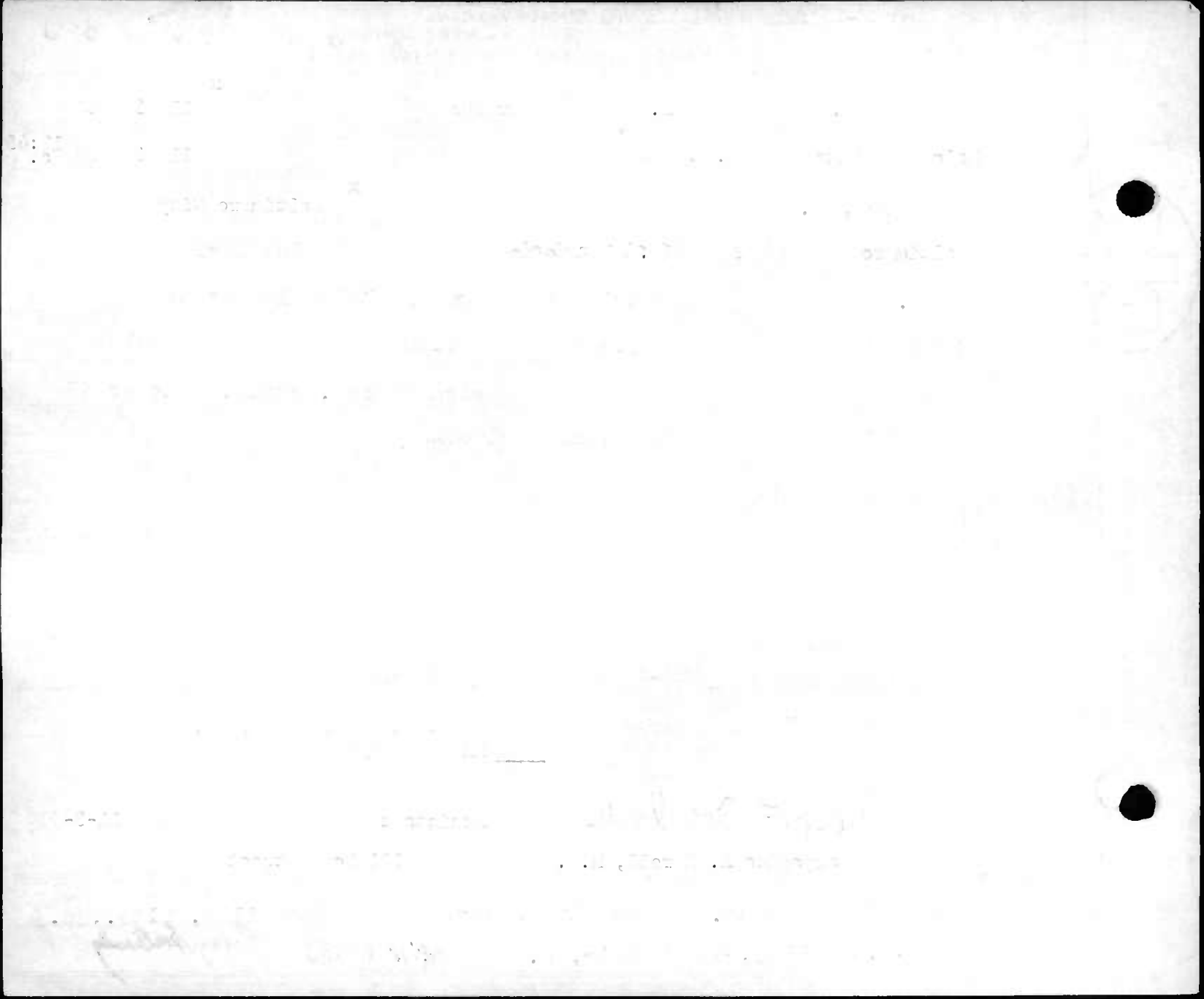
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE GIVEN TO THE DIVISION OF VITAL RECORDS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

See item 18-22 film G 551 1/19/81 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR  
 1- STATE REGISTRAR

REG. NO. 27880

|  |  |  |  |  |  |   |  |  |   |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|---|--|--|---|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  | 2a. DATE KNOWN OF DEATH  |  |  | 2b. DATE OF DEATH   |  |  | 2c. DATE PRONOUNCED DEAD  |  |  | 2d. DATE KNOWN OF DEATH  |  |  | 2e. DATE PRONOUNCED DEAD   |  |  |
| John A. Brooks   |  |  | 11 3 1980  |  |  | 11 3 1980   |  |  | 11 3 1980   |  |  | 11 3 1980  |  |  | 11 3 1980  |  |  |
| 3. SEX<br>Male   |  |  | 4. RACE<br>White   |  |  | 5. DATE OF BIRTH<br>Sept. 5, 1961   |  |  | 6. AGE (IN YEARS)<br>19 YRS.  |  |  | 7. IF UNDER 1 YR.<br>MONTHS DAYS   |  |  | 7. IF UNDER 24 HRS.<br>HOURS MIN   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Baltimore, Md.                            |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  | 8. MARRIED<br>WIDOWED   |  |  | 8. NEVER MARRIED<br>DIVORCED  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City   |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Sinai Hospital |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Shipping Clerk   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  | 12c. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.           |  |  | 13b. COUNTY<br>Baltimore   |  |  |
| 13c. CITY OR TOWN<br>Baltimore   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                              |  |  | 13e. STREET ADDRESS<br>3632 Elm Avenue  |  |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Brooks                                    |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Helen Shuler  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |  |  |
| 16b. SOCIAL SECURITY NO.   |  |  | 17. INFORMANT<br>Helen Fetsch, mother, same as 13  |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Shotgun wound of abdomen<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c) DUE TO, OR AS A CONSEQUENCE OF |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I |  |  | 19a. DATE OF OPERATION   |  |  |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                      |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  | 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  | 21b. TIME OF INJURY<br>11:20 AM 11-2-80   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>Self-inflicted                                |  |  | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK |  |  |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>neighborhood playground |  |  | 21f. LOCATION<br>CITY OR TOWN STREET COUNTY STATE<br>3400 Blk. Elm Ave, Balto, Md.   |  |  | 22a. I certify that I took charge of the remains described above, held on death resulted from:<br>Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>                                |  |  | 22b. Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |  | 22c. TITLE (SPECIFY)<br>Assistant MEDICAL EXAMINER   |  |  | 22d. DATE SIGNED<br>11-3-80  |  |  |
| ACTUAL SIGNATURE<br>Margarita A. Korell  |  |  | EXAMINER'S NAME (TYPE OR PRINT)<br>Margarita A. Korell, M.D.   |  |  | ADDRESS<br>111 Penn Street  |  |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation                                      |  |  | 23b. DATE<br>4 Nov. 80   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Security Process   |  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Catonsville, Balto., Md.                 |  |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>James S. Kirkley, Glen Burnie, Md.   |  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 6 1980   |  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |  |  | 25c. DATE REC'D. BY REGISTRAR<br>NOV 6 1980  |  |  | 25d. REGISTRAR'S SIGNATURE<br>[Signature]  |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 7 8 8 1

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Vernon W. Brooks   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 14, 1980  |  | 2b. HOUR<br>5:20 PM  |  |
| 3. SEX<br>male  |  | 4. RACE<br>Caucasian   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 2 17  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>63 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Good Samaritan Hospital |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Forrestery Dept   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Balto City  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>--  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Edward L. Brooks  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Arrington  |  | 13e. STREET ADDRESS<br>3803 Roland Ave. (21211)   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE YEAR OR DATES)<br>WW 11  |  | 17. INFORMANT<br>ADDRESS<br>Frances Brooks-3803 Roland Ave. (21211)   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Large cell lung carcinoma - metastatic</u><br>1629<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>8 mos. |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (H) (this hospital) attended the deceased from <u>10/27</u> , 19 <u>80</u> , to <u>11/14</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>11/14</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br>Paul Chang, M.D.  |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br>11/14/80   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Paul Chang, M.D.   |  | 22e. ADDRESS<br>5601 Loch Raven Blvd.; Baltimore 21239   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>11/18/80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Lake View Mem. Gdns.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Sykesville, Maryland 21784   |  |
| 24. FUNERAL DIRECTOR<br>A. Alan Seitz Funeral Home 3818 Roland Ave.   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 20 1980  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |



U.S.

U.S.

U.S. DEPARTMENT OF JUSTICE

U.S. DEPARTMENT OF JUSTICE

(1971)

- -

U.S. DEPARTMENT OF JUSTICE

U.S. DEPARTMENT OF JUSTICE

U.S. DEPARTMENT OF JUSTICE

U.S. DEPARTMENT OF JUSTICE

U.S. DEPARTMENT OF JUSTICE

U.S. DEPARTMENT OF JUSTICE

U.S. DEPARTMENT OF JUSTICE

U.S. DEPARTMENT OF JUSTICE

U.S. DEPARTMENT OF JUSTICE

U.S. DEPARTMENT OF JUSTICE

U.S. DEPARTMENT OF JUSTICE

U.S. DEPARTMENT OF JUSTICE

U.S. DEPARTMENT OF JUSTICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 7 8 8 2

REG. NO.

|  |   |  |  |   |  |
|--|---|--|--|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>ALEXANDER Paul BROWN Jr.</b>  |   |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>11-5-80</b><br>HOURS MIN.<br><b>8:10 P.M.</b>   |   |  |
| 3 SEX<br><b>Male</b>   | 4 RACE<br><b>White</b>  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4/18/1903</b>  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b><br>YRS   | 7b UNDER 1 YEAR<br>MONTHS DAYS<br><b>11 5</b>   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BALTIMORE, Md.</b>  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b><br>MD.  |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b> |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Manager</b>  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>Oil Industry</b>                                   |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br><b>Maryland</b>  |   |  | 13b COUNTY<br><b>---</b>   | 13c CITY OR TOWN<br><b>Baltimore</b>  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Alexander Paul Brown, Sr.</b>  |   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna Wilson</b>   |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>213.01.1903</b>  | 17 INFORMANT<br>ADDRESS<br><b>Helen S. Brown---Same as 13e</b>   |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Emphysema / Congestive Heart Failure</b><br>4920<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____ |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>Cancer of Larynx</b>   |   |  |  |   |  |
| 19a DATE OF OPERATION  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                            |   |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d INJURY OCCURRED<br>AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>   | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (lost) saw the deceased alive on <b>11/5</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |   |  |  |   |  |
| 22b SIGNATURE<br><b>Ann E Duer, MD</b>   |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c DATE SIGNED<br><b>11/5/80</b>  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Ann E Duer, MD</b>  |   |  | 22e ADDRESS<br><b>201 E. University Parkway 21218</b>  |   |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>  | 23b DATE<br><b>11/6/1980</b>  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Green Mount Crematory</b>  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>   | 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Walter Brooks Bradley Inc., Balto Md. 21222</b> |  |
| 25a DATE REC'D. BY REGISTRAR<br><b>NOV 10 1980</b>   |   |  | 25b REGISTRAR'S SIGNATURE<br><b>Henry McCreedy</b>   |   |  |

BP

DHMH-16 25M  
(VRA 15, 4) 1/79

11-2-30 8105

BROWN

ALEXANDER

BALTIMORE CITY

BALTIMORE

UNION MEMORIAL HOSPITAL

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 7 8 8 3

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |   |                            |  |  |
|--|--|---|---|---|----------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Bertina Brown</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 15, 1980</b> |   | 2b. HOUR<br><b>2:20P M</b> |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Negro</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 9 1912</b>   |                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>68</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balto. Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>domestic</b>   |                            | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY   |   | 13c. CITY OR TOWN<br><b>Balto.</b>  |                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Willie Gibson</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Austin</b>   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |                            | 16b. SOCIAL SECURITY NO.<br><b>220-05-7991</b>   |  |
| 17a. INFORMANT<br><b>Carolyn Thorpe</b>  |  | 17b. ADDRESS<br><b>493 Oakwood Ave</b>  |   | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b><br><b>3483</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>C Association Urinary Tract Infection</b><br><b>and Post Anoxia</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Encephalopathy and Diabetes Mellitus and Arteriosclerotic Coronary Vascular Disease</b> |                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10-26-80</b><br><b>11-14-80</b>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):<br><b>See cause of death</b>  |  |   |   |   |                            |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |                            |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                            |  |  |
| 22a. I certify that <del>XX</del> (his hospital) attended the deceased from <b>October 26</b> 19 <b>80</b> to <b>November 15</b> 19 <b>80</b> , that <del>X</del> (we) last saw the deceased alive on <b>November 15</b> 19 <b>80</b> , and that <del>in</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>X</del> (we) <del>XXX</del> (did not) view the body after death. |  |   |   |   |                            |  |  |
| 27b. SIGNATURE<br><b>Gwendolyn Wigand, MD</b>  |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>  |                            | 27c. DATE SIGNED<br><b>11-15-80</b>  |  |
| 27d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Gwendolyn Wigand M.D.</b>  |  |   |   | 27e. ADDRESS<br><b>Care of Maryland General Hospital</b>  |                            |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11-21-80</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Calvary Cem.</b>   |                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Annapolis Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Carlton C. Douglas</b>  |  | ADDRESS<br><b>669-1738</b><br><b>1612 Penn Ave.</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 17 1980</b>   |                            | 25b. REGISTRAR'S SIGNATURE<br><b>Robert M. Brady</b>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



October 1, 1940

St. Louis

St. Louis

St. Louis

St. Louis

St. Louis

St. Louis

St. Louis

St. Louis

St. Louis

St. Louis

St. Louis

St. Louis

St. Louis

St. Louis

St. Louis

St. Louis

St. Louis

Items 5,6,13e g550 12/8/80 g3

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

2 7 8 8 4

FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>FRANK EDWARD BROWN</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 12, 1980</b>  |   | 2b. HOUR<br><b>4:40AM</b>  |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>NEGROID</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11-22-42</b>   |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br>YRS. MONTHS DAYS<br><b>32</b>                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>U.C.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO.</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |   | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br><b>MD.</b>   |  | 13b. COUNTY<br><b>BALTO.</b>  | 13c. CITY OR TOWN<br><b>BALTO.</b>                               | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>FRANK BROWN</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>KATHERINE SHARP</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS<br><b>LUCILLE SHARPE Rt. 4 Box 45B, GREENVILLE, N.C.</b>                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Lactic Acidosis</b><br><b>454-9</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Hypertension</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Varicose Bleeding</b> |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hours</b><br><b>24 hours</b><br><b>7 days</b>                        |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Alcoholism</b>   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/9</b> , 19 <b>80</b> , to <b>11/12</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>11/12</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                     |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Thomas Nygaard MD</b>   |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>11/2/80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>THOMAS NYGAARD</b>   |  | 22e. ADDRESS<br><b>601 N BROADWAY</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>11/15/80</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Church Cem.</b>         |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. MD.</b>  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>VERNON BAILEY 1348 Calhoun St.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 14 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert McCreedy</b>  |  |

DIVISION OF VITAL RECORDS, 201 W. PLESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, the funeral director, or the funeral home, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





NOV 14 1960

NOVEMBER 13, 1960

BROWN

WILMINGTON CITY

JOHN W. BROWN

JOHN W. BROWN

NOV 14 1960

NOV 14 1960



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 27885

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |   |  |  |   |  |   |                                   |   |                                   |  |
|---|--|---|--|--|---|--|---|-----------------------------------|---|-----------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Haywood Brown   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 6 80                         |  | 2b. HOUR<br>M<br>AM                                       |  |   |                                   |   |                                   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Black  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6 22 25  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>55 YRS.                       |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS |   | 8. IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.       |   |                                   |   |                                   |  |
| 10. CITY OR TOWN OF DEATH<br>Balto.   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Union Mem. Hosp. |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |   | 12b. KIND OF BUSINESS OR INDUSTRY |   |                                   |  |
| 13a. STATE<br>Md.   |  |   | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Balto.                               |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   | 13e. STREET ADDRESS<br>4530 St. George Ave. |                                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Howard Brown                      |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Agusta Gassoway       |  |   |  |   |                                   |   |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>216-18-0122 |  | 17. INFORMANT ADDRESS<br>Warren Brown 5751 Edge Park Road |  |   |                                   |   |                                   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cordis rhythmically arrested

1490  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause lost

(b) Obstructive pulmonary(c) Ed. pulmonaryAPPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

7

75 min.

6 min.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

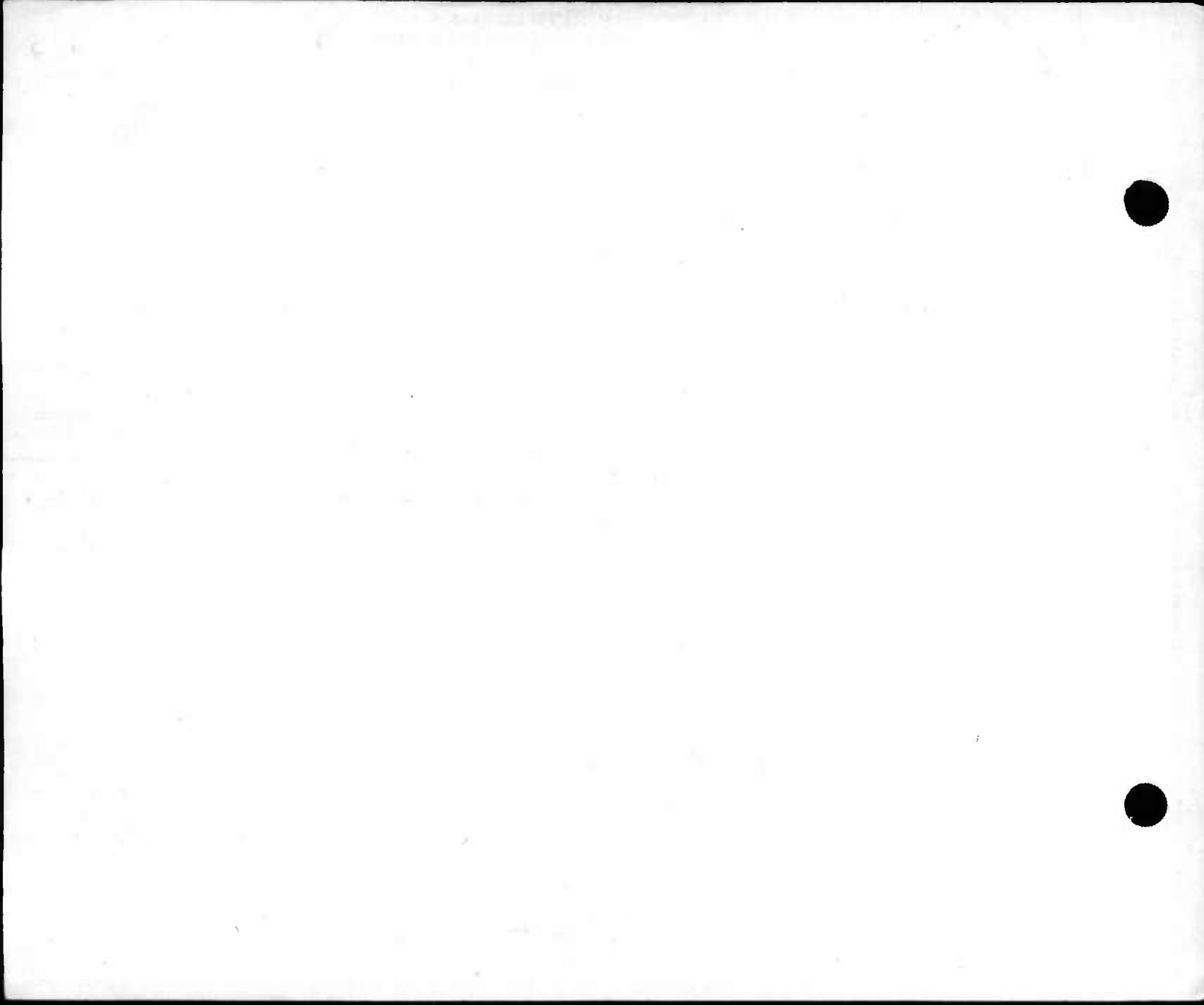
|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/4</u> , 19 <u>80</u> , to <u>11/10</u> , 19 <u>80</u> , that (I) (we) lost<br>saw the deceased alive on <u>11/4</u> , 19 <u>80</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><u>R. M. Winkler</u>  |  |  |  | DEGREE<br><u>M.D.</u>  |  | 22c. DATE SIGNED<br><u>11/17/80</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS   |  |   |  |

|   |  |                         |  |  |  |   |  |
|---|--|-------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                        |  | 23b. DATE<br>11/10/1980 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>King Memorial Park |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Wm. C. March F/H 1101 East North Ave. |  |                         |  | 25. RECEIVED BY REGISTRAR<br>NOV 10 1980                 |  | 26. REGISTRAR'S SIGNATURE<br><u>L. J. McCreedy</u>                |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80

REG. NO.

27886

|   |  |  |   |   |                                       |  |   |  |  |  |
|---|--|--|---|---|---------------------------------------|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>IRENE BROWN</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11/5/80</b>                     |   |                                       | 2b. HOUR<br><b>3:20 A.M.</b>   |   |  |  |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>BLACK</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>05 29 87</b>   |                                       | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>93</b>   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US of A</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALT. CITY</b> MD.                        |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>LUTHERAN HOSP.</b> |   |   |                                       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a. STATE<br><b>MD</b>   |  |  | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Baltimore</b> |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>3313 Poplar Street</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOHN BURLEY</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ALBERTA ARMENELLA</b> |   |                                       |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>213 05 6728D</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>MR. STEWART E. BROWN 3808 GRANTLEY ROAD</b>  |                                       |  |   |  |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CHOLANGITIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>BILIARY TRACT CANCER</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>1569</b><br>conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |   |                                       |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>KLEBSIELLA DEPOSIS</b>   |  |  |   |   |                                       |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>11/3/80</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>JAUNDICE</b>  |   |   |                                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                                       |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                       |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/5/80</b> , 19____, to <b>11/5/80</b> , 19____, that (I) (we) last saw the deceased alive on <b>11/5/80</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.                              |  |  |   |   |                                       |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Edward P. Kozak</b>  |  |  |   | DEGREE<br><b>MD</b>   |                                       |  |   | 22c. DATE SIGNED<br><b>11/5/80</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>EDWARD P. KOZAK</b>   |  |  |   | 22e. ADDRESS<br><b>LUTHERAN HOSP.</b>   |                                       |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>11/7/80</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ARBUTUS MEMORIAL PARK</b>  |                                       |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE (BALTO.) MD.</b>                     |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>LEWIS T. GWYNN</b>   |  |  |   | ADDRESS<br><b>4517 PARK HEIGHTS AVENUE</b>  |                                       |  | 25a. DATE REC'D BY REGISTRAR<br><b>NOV 7 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b> |  |

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |  |  | REG. NO. |  |
|---|--|---|--|---|--|--|--|--|--|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>JOSEPH BARTLETT BROWN SR.</b>   |  |   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>11-5-80</b>                                   |  | 2b. HOUR<br><b>4 <sup>16</sup> PM</b>  |  |          |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Nov. 9, 1888</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>91</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                    |  |  |  |          |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. JENKINS MEMORIAL HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1000 S. Caton Ave. Balt., Md. 21229</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Bookkeeper</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>J. Gutman</b>  |  |          |  |
| 13a. STATE<br><b>Maryland</b>   |  |   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |          |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>James I. Brown</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Victoria Rosensteel</b>  |  |  |  |  |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>212 10 2904</b>  |  | 17. INFORMANT ADDRESS<br><b>Mr. John D. Brown Balto., Md.</b>   |  |  |  |  |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line in 1a, 1b, and 1c.)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE 1a) <b>Congestive Heart Failure</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause 1a, stating the underlying cause last.<br>(b) <b>ASCVD</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 WK</b><br><b>15 YRS</b> |  |   |  |   |  |  |  |  |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>CHRONIC RENAL DISEASE</b>   |  |   |  |   |  |  |  |  |  |          |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |          |  |
| 22a. I certify that (he) (this hospital) attended the deceased from <b>Nov. 21</b> , 19 <b>75</b> , to <b>Nov. 5</b> , 19 <b>80</b> , that (he) (we) last saw the deceased alive on <b>Nov. 5</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (he) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |  |  |          |  |
| 22b. SIGNATURE<br><b>John F. Hartman</b>  |  |   |  | DEGREE<br><b>M.D.</b>   |  |  |  | 22c. DATE SIGNED<br><b>11-5-80</b>   |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOHN F. HARTMAN</b>   |  |   |  | 22e. ADDRESS<br><b>1000 S. CATON AVE. Balto. Md. 21229</b>  |  |  |  |  |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11/8/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Balto., Md.</b>                        |  |  |  |          |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Henry W. Jenkins &amp; Sons Co.</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 6 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert McCreedy</b>                                 |  |  |  |          |  |
| 4905 York Road Balto., Md. 21212  |  |   |  |   |  |  |  |  |  |          |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |   |  |   |  |  |                                | 80   | 27                            | 88 | 8 |                     |  |
|--|--|---|--|---|--|---|--|--|--------------------------------|--|-------------------------------|----|---|---------------------|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   |  |   |  |  |                                | REG. NO.   |                               |    |   |                     |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Joseph V Brown   |  |   |  |   |  |   |  |  |                                | 2a. DATE OF DEATH MONTH DAY YEAR<br>11-25-80   |                               |    |   | 2b. HOUR<br>1:31 PM |  |
| 3. SEX<br>Male   |  | 4. RACE<br>B  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>3 10 60  |  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>80 YRS.                 |  | IF UNDER 1 YEAR<br>MONTHS DAYS |  | IF UNDER 24 HRS<br>HOURS MIN. |    |   |                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>unknown   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD. |  |                                |  |                               |    |   |                     |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Lutheran Hospital |  |   |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |                                | 12b. KIND OF BUSINESS OR INDUSTRY  |                               |    |   |                     |  |
| 13a. STATE<br>Maryland   |  |   |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Baltimore                          |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                | 13e. STREET ADDRESS<br>1027 N. Peoa St.  |                               |    |   |                     |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>-   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>-   |  |   |  | 16. ADDRESS<br>Frances A. Jackson 1226 Seminole Ave.   |                                |  |                               |    |   |                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  |   |  | 16b. SOCIAL SECURITY NO.<br>218097067   |  | 17. INFORMANT<br>Frances A. Jackson 1226 Seminole Ave.  |  |  |                                |  |                               |    |   |                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) SEPTICEMIA<br>5990<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) URINARY TRACT INFECTION<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |   |  |   |  |  |                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |                               |    |   |                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>PNEUMONIA.  |  |   |  |   |  |   |  |  |                                |  |                               |    |   |                     |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                               |    |   |                     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |                                |  |                               |    |   |                     |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |                                |  |                               |    |   |                     |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-22-1980, to 11-25-1980, that (I) (we) lost saw the deceased alive on 11-25-1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (both) (all) view the body after death.   |  |   |  |   |  |   |  |  |                                |  |                               |    |   |                     |  |
| 22b. SIGNATURE<br>Surendra P. Paruchuri  |  |   |  | DEGREE<br>MD  |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                | 22c. DATE SIGNED<br>11-25-80   |                               |    |   |                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>SURENDRA P. PARUCHURI   |  |   |  | 22e. ADDRESS<br>LUTHERAN HOSP. BALTIMORE MD-21216   |  |   |  |  |                                |  |                               |    |   |                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>11/28/80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn Cem.   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore MD |  |  |                                |  |                               |    |   |                     |  |
| 24. FUNERAL DIRECTOR<br>Wm. C. March F/H 1101 E. North Ave.  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 28 1980            |  | 25b. REGISTRAR'S SIGNATURE<br>R. J. [Signature]  |                                |  |                               |    |   |                     |  |

BP





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 7 8 8 9

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|   |  |  |  |  |                           |  |  |
|---|--|--|--|--|---------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Lucille Brown</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 10 80</b> |  | 2b. HOUR<br><b>530 PM</b> |  |  |
| 3 SEX<br><b>Female</b>  |  | 4 RACE<br><b>Black</b>   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 31 10</b>  |                           | 6 AGE (IN YEARS (LAST BIRTHDAY))<br><b>70</b> YRS<br>IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN.             |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                           | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Provident Hospital</b> |  |  |                           | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |
| 13a STATE<br><b>Maryland</b>  |  | 13b COUNTY<br><b>Baltimore</b>   |  | 13c INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                           | 13d STREET ADDRESS<br><b>3926 Ridgewood Avenue</b>   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Neal Wilson</b>   |  | 15 MOTHER'S MAIDEN NAME<br>MIDDLE<br><b>Bertha Ford</b>  |  |  |                           |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>229-34-4288</b>   |  | 17 INFORMANT ADDRESS<br><b>Wingfield S. Brown 2812 W. North Avenue</b>   |                           |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiovascular arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Malnutrition</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) <b>Diffuse non-toxic arteriosclerosis</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br><b>Probable arteriosclerotic Cardiovascular Disease</b> |  |  |  |  |                           |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                           | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |                           |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                           |  |  |
| 22a. I certify that (a) this hospital attended the deceased from <b>11-2</b> , 19 <b>80</b> , to <b>11-10</b> , 19 <b>80</b> , that (b) (we) last saw the deceased alive on <b>11-10</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (c) (we) (did) (did not) view the body after death.  |  |  |  |  |                           |  |  |
| 22b. SIGNATURE<br><b>Patricia Jenkins, MD</b> DEGREE <b>MD</b>  |  |  |  | 22c. DATE SIGNED<br><b>11/10/80</b>  |                           |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PATRICIA JENKINS, MD</b>  |  |  |  | 22e. ADDRESS<br><b>2600 LIBERTY HILLS AVE BALTIMORE PROVIDENT HOSPITAL</b>   |                           |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11/14/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Memorial</b>  |                           | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>WILLIAM C. MARCH FUNERAL HOME INC.</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 12 1980</b>  |                           | 25b. REGISTRAR'S SIGNATURE<br><b>Robert McBrady</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the death occurs at home, the death certificate must be signed by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filed within 72 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Baltimore City

NOV 19 1980

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1. STATE  
REGISTRAR

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>MARGARET</b>   |  | FIRST MIDDLE LAST<br><b>BROWN</b>   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 11 80</b>  |  | 2b. HOUR<br><b>10<sup>25</sup> P.M.</b>  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 12 03</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>U.S.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto., Md.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>House of Pine</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>retired</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Balto.</b>  |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Oliver Wilson</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Edna Thomas</b>   |  | 13e. STREET ADDRESS<br><b>1327 N. Milton Ave.</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br>ADDRESS<br><b>Geraldine Pugh 1327 N. Milton Ave.</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for a), b), and c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>b) <b>Arteriosclerotic Vascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>c) <b>years</b> |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>—</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Diabetes mellitus; Peripheral Vascular Disease, severe; Multiple Strokes.</b>  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>6/22/1973</b> to <b>11/4/1980</b> , that (I) (we) lost saw the deceased alive on <b>11/4/1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.  |  | 22b. SIGNATURE<br><b>Albert B. Bradley</b>  |  | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>11/12/80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ALBERT B. BRADLEY, M.D.</b>  |  | 22e. ADDRESS<br><b>4900 BELAIR ROAD BALTIMORE, MD. 21206</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>11/14/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn Mem. Pk.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto., Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Leroy O. Dyett 4600 Liberty Heights Ave.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 14 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>History/Reliability</b>  |  |  |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 2 7 8 9 1  
CERTIFICATE OF DEATH

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |   |  |  |  |
|---|--|---|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Martin Joseph Brown</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>November 28, 1980</b> |   | 2b. HOUR<br><b>10 30 AM</b>   |  |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>CAUCASIAN</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>9 16 12</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b> YRS   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City MD</b>  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3528 Noble Street</b> |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>warehouseman</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Thom Lin</b> |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |  |
| 13e. STREET ADDRESS<br><b>3528 Noble Street</b>   |  |   |  |   |   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Nicholas Brown</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Margaret Britt</b>  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>215-01-6044</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Leona Brown - same</b>  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b><br><b>4/40</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 yr.</b> |  |   |  |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 5</b> 19 <b>80</b> , to <b>Nov 28</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>11/29/80</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.   |  |   |  |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Robert J. Lydek, M.D.</b>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |   | 22c. DATE SIGNED<br><b>11/29/80</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ROBERT J. LYDEK, M.D.</b>   |  |   |  | 22e. ADDRESS<br><b>6402 Golden Ring Rd Balt MD 21237</b>  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>12/1/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Stanislaus</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto</b>   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>ZANNINO FUNERAL HOME</b>   |  |   |  | 25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>DEC 1 1980</b> <b>Robert J. Lydek</b>   |   |  |  |  |
| ADDRESS<br><b>263 S. Conkling</b>   |  |   |  |   |   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.



REPORT OF THE  
COMMISSIONER OF AGRICULTURE  
FOR THE YEAR 1900

THE AGRICULTURE OF THE STATE  
IN 1900

THE AGRICULTURE OF THE STATE  
IN 1900

THE AGRICULTURE OF THE STATE  
IN 1900

**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

FOR  
STATE  
REGISTRAR

|   |         |  |                          |   |      |   |      |                                      |  |                |  |
|---|---------|--|--------------------------|---|------|---|------|--------------------------------------|--|----------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |         |  |                          | 2a. DATE KNOWN<br>OF DEATH  |      |   |      | 2b. HOUR                             |  |                |  |
| Rodell Brown  |         |  |                          | MONTH DAY YEAR<br>11 4 80   |      |   |      | M<br>2:10 P.M.                       |  |                |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH   | 6. AGE (IN YEARS)        | IF UNDER 1 YR.  |      | IF UNDER 24 HRS.  |      | 7c. DATE<br>PRONOUNCED<br>DEAD       |  | 2d. HOUR       |  |
| Male  | Black   | MONTH DAY YEAR<br>10 6 22  | LAST BIRTHDAY<br>58 YRS. | MONTHS  | DAYS | HOURS   | MIN. | MONTH DAY YEAR<br>11 6 80            |  | M<br>2:10 P.M. |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |                          | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |      | 9. BALTIMORE CITY OR COUNTY OF DEATH  |      |                                      |  |                |  |
| Maryland  |         | U.S.A.   |                          | Baltimore City MD.  |      |   |      |                                      |  |                |  |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                          |   |      | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)                                |      | 12b. KIND OF BUSINESS<br>OR INDUSTRY |  |                |  |
| Baltimore   |         | 2615 Hafer Street  |                          |   |      | Retired   |      | Environ.                             |  |                |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)        |         |  |                          |   |      |   |      |                                      |  |                |  |
| 13a. STATE  |         | 13b. COUNTY  |                          | 13c. CITY OR TOWN   |      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |      | 13e. STREET ADDRESS                  |  |                |  |
| Maryland  |         |  |                          | Baltimore   |      |   |      | 2615 Hafer Street                    |  |                |  |
| 14. FATHER'S NAME   |         |  |                          | 15. MOTHER'S MAIDEN NAME  |      |   |      |                                      |  |                |  |
| FIRST MIDDLE LAST<br>Richard Brown  |         |  |                          | FIRST MIDDLE LAST<br>Idell Cornish  |      |   |      |                                      |  |                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) |         |  |                          | 16b. SOCIAL SECURITY NO.  |      | 17. INFORMANT ADDRESS   |      |                                      |  |                |  |
| Yes WW II   |         |  |                          | 215-18-6504   |      | Richard Brown 4116 Glenhunt Ave.  |      |                                      |  |                |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I DEATH WAS CAUSED BY: **Alcoholism**

3030  
IMMEDIATE CAUSE (a) **Alcoholism**  
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.  
(b) **Alcoholism**  
(c) **Alcoholism**

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?              |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK              |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                   |  |

22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion

ACTUAL SIGNATURE *Margarita A. Korell* TITLE (SPECIFY) **Assistant** MEDICAL EXAMINER DATE SIGNED **11-7-80**  
EXAMINER'S NAME (TYPE OR PRINT) **Margarita A. Korell, M.D.** ADDRESS **111 Penn Street**

|  |  |           |  |                                    |  |  |  |
|--|--|-----------|--|------------------------------------|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) |  | 23b. DATE |  | 23c. NAME OF CEMETERY OR CREMATORY |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |  |
| Burial                                       |  | 11-12-80  |  | Md. Veterans' Cem.                 |  | Crownsville Md.                            |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS         |  |           |  | 25a. DATE REC'D. BY REGISTRAR      |  | 25b. REGISTRAR'S SIGNATURE                 |  |
| Chas. A. Rice FSPA 1300 Eutaw Pl.            |  |           |  | NOV 17 1980                        |  | <i>Chas. A. Rice</i>                       |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Post retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 7 8 9 3

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|  |                             |  |  |   |                                       |  |
|--|-----------------------------|--|--|---|---------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>SEYMOUR BROWN</b>  |                             |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 24 80</b>             |   | 2b. HOUR<br><b>11:45</b> <sup>A</sup> |  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>Caucasian</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 15 18</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b> <sup>XX</sup> <b>62</b> YRS.   |                                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York</b>   |                             | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                       |  |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York</b>   |                             |  | 9b. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore CITY</b> MD. |   |                                       |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                             | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VAMC Baltimore, Maryland 21218</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SALESMAN</b>   |                                       |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>MEN'S CLOTHING</b>   |                             |  |  |   |                                       |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>BALTIMORE</b> 13c. CITY OR TOWN <b>Owings Mills</b>  |                             |  |  |   |                                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>MAX BROWN</b>   |                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE<br><b>CHANA UNKNOWN</b>   |  |   |                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |                             | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WWII - NAVY 064-03-0161</b>  |  | 16c. ADDRESS<br><b>MRS. FLORENCE BROWN 1 HOUNDS HOLLOW CT</b>   |                                       |  |
| 17. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4275</b> IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Brain Anoxia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Previous Cardiopulmonary Arrest</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 min</b><br><b>1 day</b><br><b>1 day</b>   |                             |  |  |   |                                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |                             |  |  |   |                                       |  |
| 19a. DATE OF OPERATION<br><b>10/20/80</b>  |                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Septic stasis ulcer; osteomyelitis</b>  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |                             | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                                       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |                             | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                       |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>October 8, 19 80</b> , to <b>November 24, 19 80</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>November 24, 19 80</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death. |                             |  |  |   |                                       |  |
| 22b. SIGNATURE<br><b>James J. York</b> MD  |                             | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>11/25/80</b>   |                                       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>James J. York</b> MD   |                             | 22e. ADDRESS<br><b>VAMC, Baltimore, Maryland 21218</b>   |  |   |                                       |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>   |                             | 23b. DATE<br><b>11/26/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CHIZUK AMUNO</b>   |                                       |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>  |                             |  |  |   |                                       |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b><br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>   |                             | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 3 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Patricia Helms</b>   |                                       |  |

BP

19:15 03 00 15

19:15

19:15

03

15

15

15

19:15

19:15

19:15

19:15

19:15

19:15

19:15

19:15

19:15

19:15

19:15

19:15

19:15

19:15

19:15

19:15

19:15

19:15

19:15

19:15

19:15

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

2 7 8 9 4

REG. NO.

|   |  |  |   |   |                            |  |
|---|--|--|---|---|----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>WILLIAM BROWN</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 13, 1980</b> |   | 2b. HOUR<br>M<br><b>AM</b> |  |
| 3 SEX<br><b>Male</b>  |  | 4 RACE<br><b>Negro</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 29 91</b>   |                            |  |
| 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>89</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>0 0</b>                       |   | IF UNDER 24 HRS<br>HOURS MIN.<br><b>0 0</b>   |                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pa.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                         |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                            |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  | 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                      |   |   |                            |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Provident Hosp.</b> |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |                            |  |
| 13a. STATE<br><b>MD</b>   |  |  |   | 13b. COUNTY<br><b>Baltimore</b>   |                            |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Sylvester</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Belle Muir</b> |   |   |                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>215-03-3599</b>                     |   | 17. INFORMANT<br>ADDRESS<br><b>William C. Brown 3702 Edgewood Rd.</b>   |                            |  |

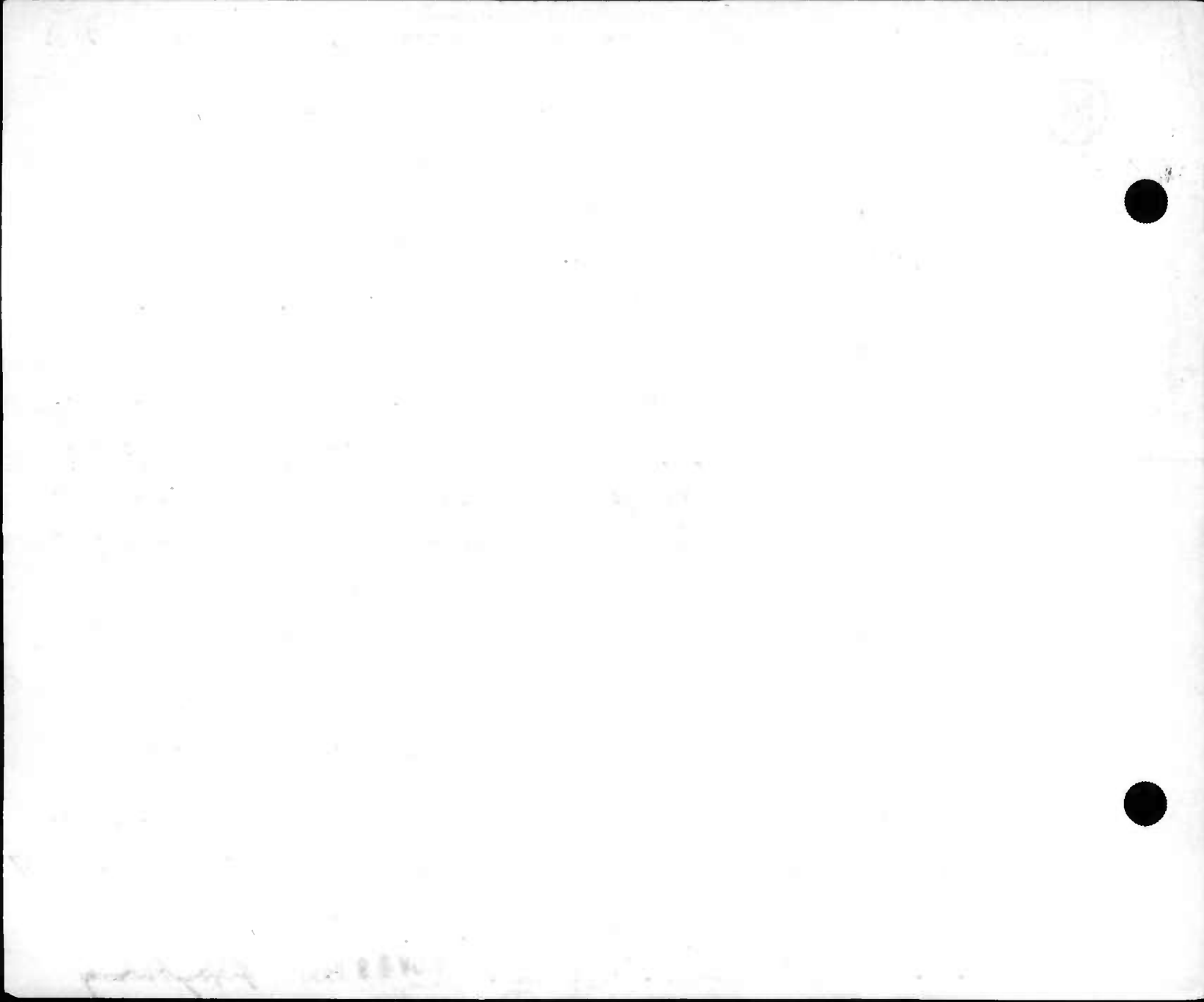
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY

|   |  |
|---|--|
| IMMEDIATE CAUSE (a) <b>Myocardial Insufficiency</b>   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b> |
| CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.<br>(b) <b>Hypertension</b> | <b>20 yrs</b>  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Generalized Arteriosclerosis</b>   | <b>20 yrs</b>  |

## PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION<br><b>None</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>January 19 76</b> to <b>November 13 19 80</b> , that (I) (we) last saw the deceased alive on <b>November 13 19 80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 27a. SIGNATURE<br><b>Marcus W. Moore Sr</b>  |  |  |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>11/18/80</b>  |  |
| 27b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Marcus W. Moore Sr MD</b>  |  |  |  | 22d. ADDRESS<br><b>1371 N. Carey St Balto. Md 21217</b>                              |  |  |  |

|  |  |                              |  |   |  |  |  |
|--|--|------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                      |  | 23b. DATE<br><b>11/19/80</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Pk.</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arbutus, Md</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H 1101 E. North Ave.</b> |  |                              |  | 25. DATE REC'D. BY REGISTRAR<br><b>NOV 19 1980</b>            |  | 26. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                  |  |





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 27895

FOR  
1- STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |  |  |   |   |  |
|---|--|---|--|---|--|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>RICHARD Stanton Brumfield  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11-20-80                                |   |  | 2b. HOUR<br>10 24 AM   |   |   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>May 6, 1912   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>68 YRS  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Penna.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Designer   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>US-govt. Ret.  |  |
| 13a. STATE<br>Maryland  |  |   | 13b. COUNTY<br>Harford   |   | 13c. CITY OR TOWN<br>Darlington                          |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Philip Sherwood Brumfield   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Corinne -- Tyson              |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no   |   |   |  |
| 16b. SOCIAL SECURITY NO.<br>213-18-1932   |  |   | 17. INFORMANT ADDRESS<br>Mrs. Sara W. Brumfield, Darlington, Md.               |   |  |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u><br><u>4149</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>LOW CARDIAC OUTPUT</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(c) <u>CORONARY ARTERY BYPASS GRAFT</u> |  |   |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 HRS<br>4 HRS<br>1 DAY   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>no</u>  |  |   |  |   |  |  |   |   |  |
| 19a. DATE OF OPERATION<br>11-19-80  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>CORONARY ARTERY DISEASE    |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)         |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 19th</u> 19 <u>80</u> , to <u>Nov 20th</u> 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>Nov 20</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                        |  |   |  |   |  |  |   |   |  |
| 22b. SIGNATURE<br>Charles John Yeo  |  |   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br>11/20/80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>CHARLES JOHN YEO   |  |   |  |   |  | 22e. ADDRESS<br>JOHNS HOPKINS HOSPITAL   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation   |  |   | 23b. DATE<br>Nov. 21, 1980   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Crematory |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md.                                     |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Howard K. McComas III, Abingdon, Md.  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 24 1980   |   | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



NOV 2 1990

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

80 27896

1. FOR  
STATE  
REGISTRAR

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARY</b> <b>Brunswick</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR <b>11 29 80</b> |  |  | 2b. HOUR <b>1:10 AM</b>  |  |
| 3. SEX <b>Female</b>  |  | 4. RACE <b>Black</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>5 29 14</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>66 YRS</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Lafayette Square Nursing</b>                      |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>   |  |
| 13a. STATE <b>Maryland</b>  |  | 13b. COUNTY <b>BALTO</b>  |  | 13c. CITY OR TOWN <b>BALTO</b>   |  | 13d. STREET ADDRESS <b>1800 N. Fulton Avenue</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>JAMES E. BRUNSWICK</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ELIZABETH CLINTON</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>   |  | 16b. SOCIAL SECURITY NO. <b>218221334</b>   |  | 17. INFORMANT <b>Mr William Holland 6711 Conahill Road</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Probable myocardial infarct</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Diabetes Mellitus</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Peripheral vascular disease</b>                              |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 yr</b> |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |  |  |
| 22b. SIGNATURE <b>A. M. Naem</b>  |  | DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |  | 22c. DATE SIGNED <b>11/29/80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR A M NAEM</b>  |  | 22e. ADDRESS <b>501 Dolphin St Baltimore</b>  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>   |  | 23b. DATE <b>12-3-80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cem</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO MD</b>  |  |
| 24. FUNERAL DIRECTOR NAME <b>Joseph H. Run</b> ADDRESS <b>2222 W NORTH AVE</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>DEC 1 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>Richard H. Boring</b>  |  |

*[Faint, illegible handwritten text]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80

27897

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |                                      |   |   |
|--|--|---|--|---|--------------------------------------|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>CORDELIA BRYANT</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11-10-80</b> |   | 2b. HOUR<br><b>7<sup>48</sup> PM</b> |   |   |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>CAUCASIAN</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 6 1887</b>   |                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>93</b> YRS  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>UNKNOWN Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>UNKNOWN USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY</b> MD.   |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>LUTHERAN HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>  |                                      | 12b. KIND OF BUSINESS OR INDUSTRY   |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   |                                      |   |   |
| 13a. STATE<br><b>MD.</b>   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |                                      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN Thomas Jackson</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Effie Parker</b>  |                                      |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>UNKNOWN No</b>  |  | 16b. SOCIAL SECURITY NO<br><b>213-54-0305</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Ethel L. Proescher 410 Newburg Avenue</b>   |                                      |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute CARDIOPULMONARY ARREST</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic CARDIOVASCULAR DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>C</b>                       |  |   |  |   |                                      |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>CEREBROVASCULAR ACCIDENT</b>   |  |   |  |   |                                      |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                      | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                                      |   |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                      |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11-3-1980</b> , to <b>11-10-1980</b> , that (I) (we) lost<br>saw the deceased alive on <b>11-10-1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |                                      |   |   |
| 22b. SIGNATURE<br><b>G A Manko</b>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |                                      | 22c. DATE SIGNED<br><b>11-10-80</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>GARY A. MANKO, M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>730 ASHBURTON ST, BALTIMORE, MD. 21216</b>   |                                      |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11/14/1980</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Old Oakland</b>  |                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Oakland Mill, Carroll, Md.</b>   |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>G. Truman Schwab 5151 Balto. Nat'l. Pike</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 18 1980</b>   |                                      | 25b. REGISTRAR'S SIGNATURE<br><i>Barney McCreedy</i>  |   |

BP

DHMH-16 25M  
(VRA 15, 4) 1/79

Thomas Jackson Effie Parker  
Mrs. Ethel L. Proescher 410 Newburg Avenue

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 2 7 8 9 8  
CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |  |   |  |  |  |                                  |  |              |  |  |  |
|---|--|---|--|---|--|---|--|--|--|----------------------------------|--|--------------|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST MABEL   |  | MIDDLE  |  | LAST BRYANT   |  | 2a. DATE OF DEATH  |  | MONTH NOVEMBER                   |  | DAY 10, 1980 |  | YEAR 8:50AM                                  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Negro  |  | 5. DATE OF BIRTH<br>MONTH 4 12 28   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>52   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |  | 8. IF UNDER 24 HRS<br>HOURS MIN. |  |              |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>S.C.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY  |  |  |  |                                  |  |              |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>JOHNS HOPKINS HOSPITAL |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |                                  |  |              |  |  |  |
| 13a. STATE<br>MD  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>2427 E. Hoffman St.   |  |                                  |  |              |  |  |  |
| 14. FATHER'S NAME<br>FIRST Rainey   |  | MIDDLE  |  | LAST Moultrie   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST Virginia  |  | MIDDLE   |  | LAST Hartwell                    |  |              |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212-32-9229  |  | 17. INFORMANT<br>Troy Bryant  |  | ADDRESS<br>1327 N. Port St.   |  |  |  |                                  |  |              |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u><br>1749<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Metastatic Breast Cancer 2-lung, Brain, Spine</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |   |  |  |  |                                  |  |              |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |   |  |  |  |                                  |  |              |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                  |  |              |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |                                  |  |              |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |                                  |  |              |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/9</u> , 19 <u>80</u> , to <u>11/9</u> , 19 <u>80</u> , that (I) (we) lost<br>saw the deceased alive on <u>11/9</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |  |  |                                  |  |              |  |  |  |
| 22b. SIGNATURE<br><u>Kim M. Fehle</u>   |  | DEGREE<br>MD  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  |   |  | 22c. DATE SIGNED<br><u>11/9/80</u>   |  |                                  |  |              |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Kim Fehle</u>   |  | 22e. ADDRESS<br><u>Johns Hopkins Hospital</u><br><u>Baltimore, MD 21205</u>   |  |   |  |   |  |  |  |                                  |  |              |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>11/14/80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Church Cem.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Charleston S.C.</u>                            |  |  |  |                                  |  |              |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H  |  | ADDRESS<br>1101 E. North Ave.   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 12 1980  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Randy Roberts</u>  |  |  |  |                                  |  |              |  |  |  |

MEDICAL CERTIFICATION

COPIES OF THE REPORT OF THE  
COMMISSIONER OF THE GENERAL LAND OFFICE  
TO THE SECRETARY OF THE INTERIOR  
FOR THE YEAR 1894

MADE:

1895

1895

1895

1895

1895

1895

1895

1895

1895

1895

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

2 7 8 9 9

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |                            |  |  |  |  |   |  |
|---|--|--|--|---|----------------------------|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ALBERT E. Bubb JR.</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 26 80</b> |   | 2b. HOUR<br><b>4 19 AM</b> |  |  |  |  |   |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>CAUCASIAN</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 2 1925</b>  |                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>55</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>  |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MERCY HOSPITAL</b> |  |   |                            | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Time-keeper</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Lumber Co.</b>   |  |   |  |
| 13a. STATE<br><b>MD.</b>  |  |  |  |   |                            | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>BALTO.</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 13e. STREET ADDRESS<br><b>3614 KENYON AVE.</b>  |  |  |  |   |                            |  |  |  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ALBERT E. BUBB SR.</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE<br><b>DOROTHY HAUGHY</b>   |                            |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE YEAR OR DATES)<br><b>WW II</b>   |  | 17. INFORMANT<br><b>DORIS BUBB (WIFE)</b>   |                            | ADDRESS<br><b>SAME ADDRESS</b>   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Gram Negative Sepsis</b><br><b>3400</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Chronic Foley</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>multiple Sclerosis</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>96 hr.</b><br><b>X yr</b><br><b>X yr</b> |  |  |  |   |                            |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Stress ulcer with bleeding</b>  |  |  |  |   |                            |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |                            | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>11A</b> 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>NIA</b>   |                            |  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>NIA</b>   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>NIA</b>   |                            |  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/23</b> 19 <b>80</b> , to <b>11/26</b> 19 <b>80</b> , that (I) (we) lost<br>saw the deceased alive on <b>11/26</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |                            |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>S. Scalia</b>  |  |  |  |   |                            | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11/26/80</b>  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SCALIA</b>  |  |  |  |   |                            | 22e. ADDRESS<br><b>301 St Paul S.</b>  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>11/29/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith</b>   |                            | 23d. LOCATION<br>CITY OR TOWN COUNTY<br><b>Balto. Md.</b>  |  |  |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>SCHITONEK : FUNERAL HOME, INC.</b>   |  |  |  |   |                            | 25. DATE REC'D. BY REGISTRAR<br><b>NOV 26 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>R. Kelly</b>  |  |   |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



*[Handwritten signature]*

NOV 28 1960

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrant, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 80 27900  
CERTIFICATE OF DEATH

|  |  |  |  |
|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO.   |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | 2a. DATE OF DEATH  |  |
| FIRST MIDDLE LAST<br>VERA WAGNER BUCHER  |  | MONTH DAY YEAR<br>November 2, 1980   |  |
| 3. SEX   |  | 2b. HOUR   |  |
| Female   |  | 7:00 AM  |  |
| 4. RACE  |  | 5. DATE OF BIRTH   |  |
| White  |  | MONTH DAY YEAR<br>Dec. 24, 1892  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR  |  |
| 87 YRS.  |  | IF UNDER 24 HRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |
| Maryland   |  | USA  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |
| Baltimore  |  | One E. University Pkwy.  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| Homemaker  |  | Own Home   |  |
| 13a. STATE   |  | 13b. COUNTY  |  |
| Maryland   |  | Baltimore  |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  |
| FIRST MIDDLE LAST<br>George Wagner   |  | FIRST MIDDLE LAST<br>Frances Kalmey  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  |
| No   |  | 216 46 5916  |  |
| 17. INFORMANT  |  | ADDRESS  |  |
| Mr. Irvin F. Bucher  |  | Same   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest *</u>  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br><u>4292</u>  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>* Found dead in bed @ 9 AM.</u>  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASCVD</u>  |  | 10 1/2 years.  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |
| N.A.   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
|  |  |  |  |
| 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?   |  |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY  |  |
|  |  | HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  |
| WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |  |
| 21f. LOCATION  |  | CITY OR TOWN COUNTY STATE  |  |
| STREET   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/16/75</u> 19 <u>80</u> , to <u>11/2/80</u> 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>10/30/80</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE   |  | 22c. DATE SIGNED   |  |
| <u>A. A. Silver</u>  |  | 11-3-80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |
| Dr. A. A. Silver, M.D.   |  | 6210 Park Heights Ave., Balto., Md.  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  |
| Burial   |  | 11/4/80  |  |
| 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION  |  |
| Loudon Park  |  | Baltimore, Md.   |  |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE REC'D. BY REGISTRAR  |  |
| NAME ADDRESS<br>Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., Md. 21212  |  | NOV 3 1980   |  |
| 25b. REGISTRAR'S SIGNATURE   |  |  |  |
|  |  |  |  |



Family: White  
Married: U  
Birth: Baltimore  
Chas. E. University Hwy.  
Home: Baltimore  
Chas. E. University Hwy.  
Wagner  
F. Wagner  
Irvin F. Luchan  
No

Dr. A. A. Silver, M.D.  
11470  
Henry W. Jenkins & Son Co.  
215 York Road, Balto., Md. 21212  
215 York Road, Balto., Md. 21212  
215 York Road, Balto., Md. 21212



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 27901

REG. NO.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>George NMI Budahazy  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>11 20 80 |   |  | 2b. HOUR<br>12 noon M   |  |
| 3. SEX<br>male  |  | 4. RACE<br>white  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>05 09 12   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS<br>68  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>XXXXXX Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore City   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>univ. of MD Hospital |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Ret. Balto. City Worker  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br>MD  |  | 13b. COUNTY<br>-----  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 13e. STREET ADDRESS<br>1511 Locust St.  |  | 14. FATHER'S NAME FIRST MIDDLE LAST<br>Charles Budahazy   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Maria Zeichuk   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES<br>XXXXXX YES -- WW II  |  | 16b. SOCIAL SECURITY NO.<br>212 01 6847   |  | 17. INFORMANT<br>Budahazy, Michael  |  | ADDRESS<br>1511 Locust St. 21226  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u><br>4310<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Massive intracerebral bleed</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertension</u> |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1/2 hour<br>48 hrs<br>years   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION<br>---   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>---   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from 11/19/80, 19 80, to 11/20, 19 80, that (1) (we) lost the deceased alive on 11/20, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br>Laurence Austin Doyle   |  |   |  | DEGREE<br>MD  |  | 22c. DATE SIGNED<br>11/20/80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>LAURENCE Austin Doyle MD   |  |   |  | 22e. ADDRESS<br>4008-C Linwood RD Balt. MD 21210  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>11/24/80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Cross Cemetery   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore Anne Arundel Md.   |  |
| 24. FUNERAL DIRECTOR<br>Mc Cully Funeral Home of Curtis Day<br>4200 Pennington Ave. Balto., Md. 21226   |  |   |  | 25a. DATE RECD. BY REGISTRAR<br>NOV 25 1980   |  | 25b. REGISTRAR'S SIGNATURE<br>Pietro Habrady  |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 of 4 retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

Handwritten signature

May 2 1960

Handwritten notes, possibly "2000" and "1000"

Handwritten circled text, possibly "A"

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 27902

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|   |  |  |  |  |                                     |  |  |
|---|--|--|--|--|-------------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Louise Buie</i>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>11 17 80</i> |  | 2b. HOUR<br><i>1:55<sup>A</sup></i> |  |  |
| 3 SEX<br><i>♀</i>   |  | 4 RACE<br><i>Black</i>   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><i>10 17 03</i>   |                                     | 6 AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><i>77</i>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>N.C.</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                     | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.   |  |
| 10 CITY OR TOWN OF DEATH<br><i>Balto.</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Baltimore City Hosp.</i> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |                                     | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><i>MD</i>   |  | 13b. COUNTY<br><i>✓</i>  |  | 13c. CITY OR TOWN<br><i>Balto.</i>   |                                     | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Will Mc Clain</i>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Dollie Leslie</i>  |  | 17. INFORMANT ADDRESS<br><i>2515 E. Biddle St.</i>   |                                     |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>   |  | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br><i>241-24-9686</i>   |  | 17. INFORMANT ADDRESS<br><i>Elizabeth Jackson 204 Collins Ave.</i>   |                                     |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br><i>4321</i> IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Probable Sudden</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost |  |  |  |  |                                     |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |                                     |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                                     |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                                     |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>11/17/80</i> , 19____, to _____, 19____, that (I) (we) last saw the deceased alive on <i>11/17/80</i> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                    |  |  |  |  |                                     |  |  |
| 22b. SIGNATURE<br><i>M. Welinsky</i>  |  | DEGREE<br><i>M.D.</i>  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                 |                                     | 22c. DATE SIGNED<br><i>11/17/80</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>M. Welinsky</i>   |  | 22e. ADDRESS<br><i>B.C.H.</i>  |  |  |                                     |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>  |  | 23b. DATE<br><i>11/21/80</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>King Mem. Pk.</i>   |                                     | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Baltimore Co., Md.</i>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Wm C March F/H</i>   |  | ADDRESS<br><i>1101 E. North Ave.</i>   |  | 25a. DATE REC'D. BY REGISTRAR<br><i>NOV 19 1980</i>  |                                     | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |



1947

084 6 1 001

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 27903

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|  |   |   |   |  |   |
|--|---|---|---|--|---|
| 1. DECEASED NAME<br>(LAST, FIRST, MIDDLE)<br><b>Michael <del>XXXXXXXX</del> Ross BURKE, Jr.</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 22 80</b>  |  | 2b. HOUR<br>MIN.<br><b>12:45A</b>   |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 21 80</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>16 hrs</b>  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>16</b>  |   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MD.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO CITY</b>                                       |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO CITY</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MERCY HOSP.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>none</b>                 | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>none</b>                                     |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE COUNTY CITY OR TOWN<br><b>Maryland Baltimore</b>   |   |   | 13b. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13c. STREET ADDRESS<br><b>8434 Bussendius Road</b>                                   |   |
| 14. FATHER'S NAME<br>MIDDLE<br><b>MIKE Ross BURKE, Sr.</b>   |   | 15. MOTHER'S MAIDEN NAME<br>MIDDLE<br><b>JESSIE D. LOVE</b>   |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  | 16b. SOCIAL SECURITY NO.<br><b>none</b>   | 17. INFORMANT<br>ADDRESS<br><b>Severn, Charlotte Love, 1418 Disney Rd., Md.</b>   |   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Vascular collapse Cardiac arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Severe hyaline membrane disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Severe prematurity</b>                                    |   |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |   |   |   |  |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-21</b> , 19 <b>80</b> , to <b>11-22</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>11-22</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. |   |   |   |  |   |
| 22b. SIGNATURE<br><b>Monica Elstake</b>  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   | 22c. DATE SIGNED<br><b>11-22-80</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Monica Elstake</b>   |   | 22e. ADDRESS<br><b>Mary Hospital, Baltimore, Md.</b>  |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>11/25/80</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Cem.</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Brettnowood Maryland</b>            |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Beall Funeral Home 16000 Annapolis Rd., Bowie, Md.</b>  |   | 25a. NOV 28 1980<br>25b. REC'D<br>25c. REGISTRAR'S SIGNATURE  |   |  |   |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP



XXXXXXgI 2014

2209

going

• • • • •

9007

0000

8454 Bussell's Bunting

X

1990

Page 1 of 20

2202

72

Severn, Wm. R. Mc.

3100

92

10000 Annapolis Rd., Bowie, Md.  
Beall Funeral Home  
11252480 Rt. Lincoln Cem., Brentwood, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 80 27904   |  |
|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | LAWRENCE E. BURKINS  |  | REG. NO.   |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | LAWRENCE E. BURKINS  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  |
| Male   |  | White  |  | 4 25 1908  |  |
| 6a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| Pennsylvania   |  | USA  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |
| Baltimore  |  | The Good Samaritan Hosp.   |  | Baltimore City, MD. Paper Hanger Home Decorator  |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  |
| md   |  | Baltimore  |  | 21234  |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| William F. Burkins   |  | Lillie Anna Ellis  |  | 13e. STREET ADDRESS  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO  |  | 17. INFORMANT ADDRESS  |  |
| No   |  | 188-03-0717  |  | Gladys S. Burkins Baltimore, Md. 21234   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Heart failure<br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) myocardial infarction<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>Chronic obstructive pulmonary Disease and Renal failure |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                                  |  |
|  |  | P.M. 19  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |
|  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/1/80, 1980, to 11/10, 1980, that (I) (we) last saw the deceased alive on Nov. 10th, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |
| 22b. SIGNATURE   |  | DEGREE   |  | 22c. DATE SIGNED   |  |
| Nabil Zagluma  |  | MD   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  |
| Nabil E. Zagluma M.D.  |  | The Good Samaritan Hosp.   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |
| Burial   |  | Nov. 14, '80   |  | Lake View Mem. Gar. Carroll Co., Md.   |  |
| 24. FUNERAL DIRECTOR NAME  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |
| William E. Johnson 8521 Loch Raven Blvd.   |  | NOV 12 1980  |  |  |  |

0428 1 102



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 7 9 0 5

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|  |  |  |  |   |  |  |  |   |  |  |  |   |  |
|--|--|--|--|---|--|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>WILLIAM BUSH</b>  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>11/7/80</b> |   |  | 2b. HOUR<br><b>1230 A</b>  |  |   |  |  |  |   |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>BLACK</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 4 94</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b> YRS   |  | 7. UNDER 1 YEAR<br>MONTHS DAYS<br><b>56</b>   |  | 8. UNDER 24 HRS<br>HOURS MIN.<br><b>56</b>   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO CITY</b> MD                                 |  |   |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UMAB</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SHOE SHINE PERSON</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |   |  |
| 13a. STATE<br><b>MD.</b>   |  |  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>BALTO.</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  | 13e. STREET ADDRESS<br><b>827 ARRLINGTON AVE.</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Walter Bush</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Kates</b>   |  |  |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>214-01-8091</b>  |  | 17. INFORMANT<br><b>ADMISSION SHEET - NO SP.</b>   |  |   |  | ADDRESS  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>4310</b><br>IMMEDIATE CAUSE (a) <b>Brain stem hemorrhage</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Hypertension</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last</b> |  |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>12 days</b>   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION<br><b>—</b>   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>—</b>  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>—</b>   |  |   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>—</b>  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>—</b>                                |  |   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10-25</b> 19 <b>80</b> , to <b>11/7</b> 19 <b>80</b> ; that (I) (we) last saw the deceased alive on <b>11/6</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                          |  |  |  |   |  |  |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Kayser</b>  |  |  |  | DEGREE  |  |  |  | 22c. DATE SIGNED  |  |  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KASARAM</b>  |  |  |  | 22e. ADDRESS<br><b>University of MD</b>   |  |  |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>11/12/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MD. National Men. PK</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>LAUREL MD.</b>                              |  |   |  |  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>LOCKS FUNERAL HOME</b>  |  |  |  | ADDRESS<br><b>13047 Central AT</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 12 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Harry McHenry</b>  |  |  |  |   |  |

*[Faint, illegible handwriting on lined paper]*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 7 9 0 6

REG. NO.

|   |  |   |   |   |  |  |  |
|---|--|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Albert J. Buttner</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>11-17-80</b> |   |  | 2b. HOUR<br><b>6:15 PM</b>   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 23 1908</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Poplar Manor Nursing Home</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Vendor</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Mem. Stadium</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Dundalk</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Albert C. Buttner</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mathilde Dahlke</b>   |   | 16. SOCIAL SECURITY NO.<br><b>219-07-2381</b>   |  | 17. INFORMANT<br><b>Erma Kachele</b>   |  |
| 18a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 18b. SOCIAL SECURITY NO.<br><b>219-07-2381</b>  |   | 17. INFORMANT<br><b>Erma Kachele</b>  |  | ADDRESS<br><b>1936 Guy Way Balto, MD 21222</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio pulmonary Arrest</b><br>4292<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Atherosclerotic Cardio Vascular</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost }<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____ |  |   |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): _____  |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11-17-80</b> to <b>11-17-80</b> , that (I) (we) lost<br>saw the deceased alive on <b>11-17-80</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |  |  |  |
| 22b. SIGNATURE<br><b>[Signature]</b>  |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>11-18-80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Nair</b>  |  |   |   | 22e. ADDRESS  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>11/20/80</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Western Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Duda-Ruck, Inc.</b>  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 20 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |
| 7922 Wise Avenue, Dundalk, MD 21222   |  |   |   |   |  |  |  |

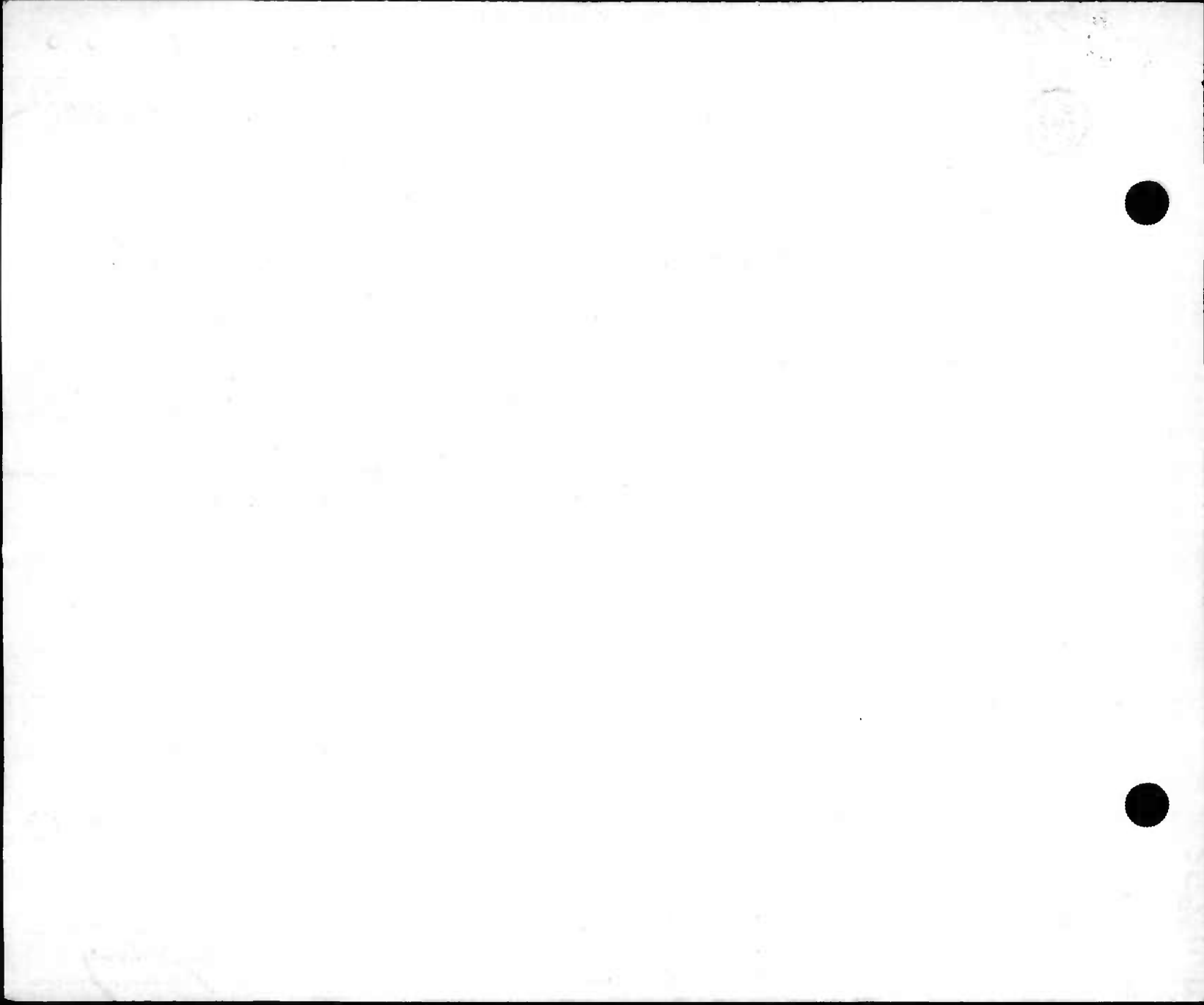
BP \_\_\_\_\_

DHMH-16 20M  
(VRA 15, 4) 7/78

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 80 27907   |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  | CERTIFICATE OF DEATH   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  | 2a. DATE OF DEATH  |  |   |  |
| FIRST MIDDLE LAST   |  |  |  | MONTH DAY YEAR   |  |   |  |
| Leroy Byrd  |  |  |  | 11 6 80  |  |   |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  |
| M   |  | NEGRO  |  | 7 10 27  |  | 53  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |
| ?   |  | U.S.A.   |  |  |  | BALTIMORE CITY MD.  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| Balt.   |  | THE JOHNS HOPKINS HOSP.  |  | ENTERTAINER  |  |   |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  |
| MD  |  |  |  | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |   |  |
| ?   |  | ?  |  | NO   |  |   |  |
|   |  |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS   |  |
|   |  |  |  | 260 05-5867  |  | JOANN Wilson 1237 N. Broadway                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY:  |  |  |  |  |  |   |  |
| IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>   |  |  |  |  |  |   |  |
| 4380 DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |  |  |   |  |
| (b) <u>Congestive Heart Failure</u>   |  |  |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |   |  |
| (c)   |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |
|   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
|   |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |   |  |
|   |  | P.M. 19  |  |  |  |   |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION  |  |   |  |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  |  | STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/5/80</u> , 19 <u>80</u> , to <u>11/6/80</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>11/5/80</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE  |  |  |  | DEGREE   |  | 22c. DATE SIGNED  |  |
| <u>B. Gelman MD</u>   |  |  |  |  |  | 11/6/80   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS   |  |   |  |
| Gelman  |  |  |  | Johns Hopkins Hospital   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  |
| Burial  |  | 11/11/80   |  | Mt. Calvary  |  | CITY OR TOWN COUNTY STATE   |  |
|   |  |  |  |  |  | BALTIMORE MD.   |  |
| 24. FUNERAL DIRECTOR  |  |  |  | 25a. DATE RECD. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |
| LOCK'S FUNERAL HOME   |  |  |  | NOV 12 1980  |  | <u>[Signature]</u>  |  |
| ADDRESS   |  |  |  |  |  |   |  |
| 13047 Central Ave   |  |  |  |  |  |   |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80

27908

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Odell Byrd |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>11 17 80 |  |  | 2b. HOUR<br>520P M  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Black   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 7 21   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>59 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>SC                        |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD                                      |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University Hospital |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br>Md.  |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Hazel Byrd Sr.               |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Julia Foster  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, GIVE WAR OR DATES)<br>Yes WWII   |  | 16b. SOCIAL SECURITY NO.<br>250-12-87K6   |  |
| 17. INFORMANT<br>HAZEL BYRD JR.  |  | ADDRESS<br>505 N. DENISON ST.<br>BALTO, MD 21229   |  | 18. DATE OF DEATH<br>11/17/80  |  | 19. TIME OF DEATH<br>5:20 PM  |  |

11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Cardio-pulmonary arrest

9110  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost

DUE TO, OR AS A CONSEQUENCE OF

(b) Adult respiratory distress syndrome

8 hours

DUE TO, OR AS A CONSEQUENCE OF

(c) Gastric aspiration

8 hours

## PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Chronic Alcoholism, seizure disorder

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov 17, 1980, to Nov 17, 1980, that (I) (we) last saw the deceased alive on Nov 17, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>AZ Kelley   |  | DEGREE<br>MD   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>11/17/80   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>David E Kelley   |  | 22e. ADDRESS<br>University Hospital, Baltimore, MD.                    |  |  |  |  |  |

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial |  | 23b. DATE<br>11/23/80                   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Memorial |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO, Co. Maryland |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wanda M. Uchale        |  | ADDRESS<br>3405 W. Franklin St - Balto. |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 19 1980            |  | 25b. REGISTRAR'S SIGNATURE<br>R. J. Brady                         |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

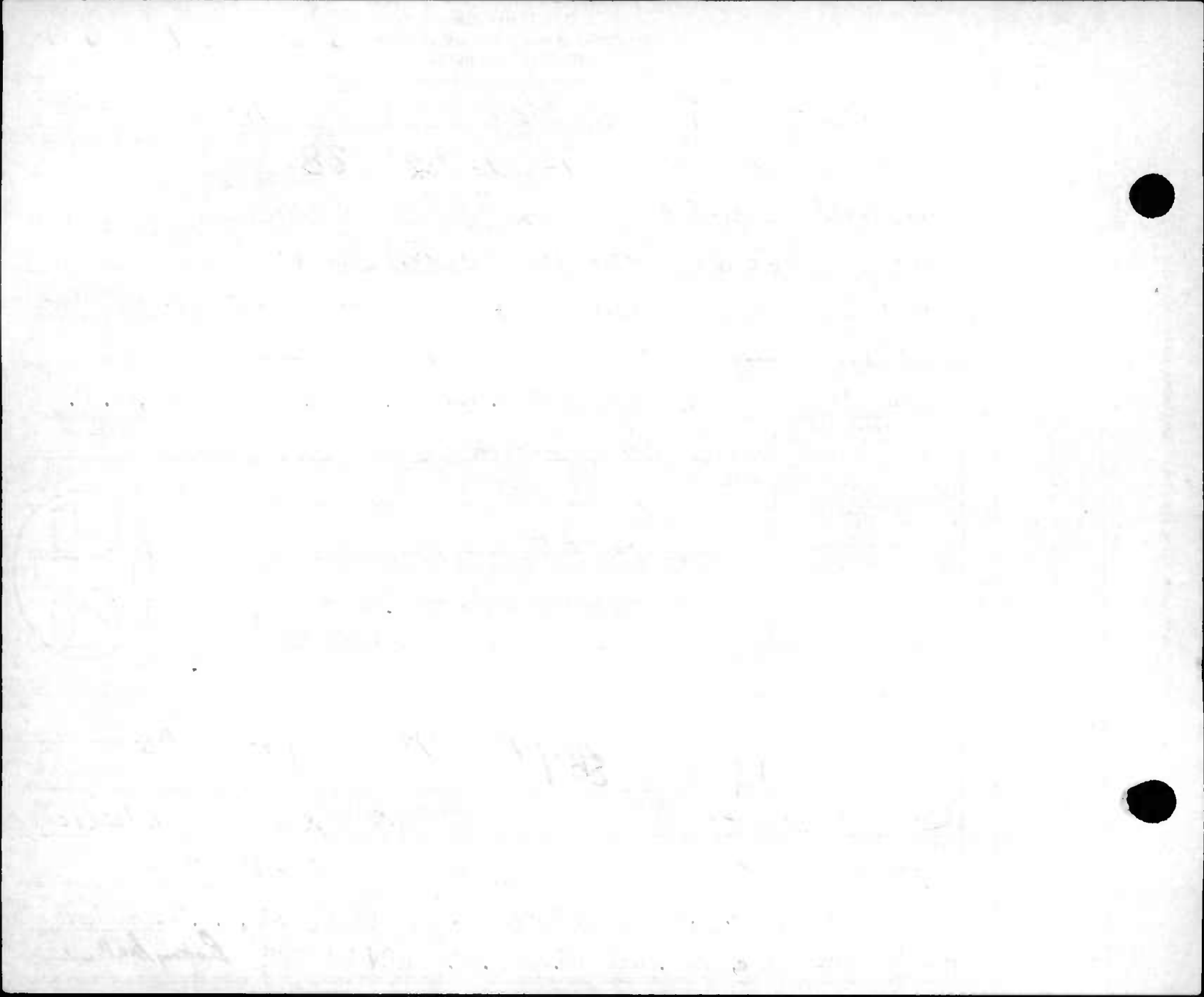
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-2229.

2.









FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 7 9 1 0

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Genard H. Cake</b>  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 23, 1980</b>  |  | 2b. HOUR<br>M<br><b>M</b>  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Feb. 15, 1904</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS HOURS MIN.<br><b>76</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N.J.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>      |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3213 Rosekemp Avenue</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Balto. Ship Yard</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John M. Cake</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mable Smallwood</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>147-07-9477</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Dolores Carey same</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>POSSIBLE MYOCARDIAL INFARCTION</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ASCVD</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>ATRIAL FIBRILLATION; Bilateral Inguinal Hernia</b>   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11-14</b> , 19 <b>77</b> , to <b>11-14</b> , 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>11-14</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                        |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Amado Vargas</b>  |  |  |  | DEGREE<br><b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11-25-80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Donato Vargas MD</b>   |  |  |  | 22e. ADDRESS<br><b>North Charles General Hosp. Baltimore, Md.</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Nov. 28, 1980</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Leonard J. Ruck Inc. Baltimore, Maryland</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 26 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Patricia Kennedy</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



WINDY WINTER

1902-1903

NOV 2 1890

*[Handwritten signature]*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |  |                            |  |                 |  |         |  |      |  |          |  |
|--|--|---|--|---|--|---|--|----------------------------|--|-----------------|--|---------|--|------|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST   |  | MIDDLE  |  | LAST  |  | 2a. DATE OF DEATH          |  | MONTH           |  | DAY     |  | YEAR |  | 2b. HOUR |  |
| Mr. Chowning Franklin Callahan   |  |   |  |   |  |   |  | 11 3 80                    |  | 5-18A           |  |         |  |      |  |          |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR            |  | IF UNDER 24 HRS |  |         |  |      |  |          |  |
| Male   |  | White   |  | 18 19 11  |  | 69  |  | MONTHS                     |  | DAYS            |  | HOURS   |  | MIN  |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                            |  |                 |  |         |  |      |  |          |  |
| Richmond Co. Va.   |  | U.S.A.  |  |   |  | BALT. CITY.   |  |                            |  |                 |  |         |  |      |  |          |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                            |  |                 |  |         |  |      |  |          |  |
| BALT.  |  | North Charles Gen. Hosp.  |  | Self Employed-Carpenter   |  |   |  |                            |  |                 |  |         |  |      |  |          |  |
| 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS        |  |                 |  |         |  |      |  |          |  |
| Mo   |  | Balt.   |  | Reisterstown  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 204 CHURCH RD. 21136       |  |                 |  |         |  |      |  |          |  |
| 14. FATHER'S NAME  |  | MIDDLE  |  | LAST  |  | 15. MOTHER'S MAIDEN NAME  |  | FIRST                      |  | MIDDLE          |  | LAST    |  |      |  |          |  |
| ARTHUR   |  | B   |  | CALLAHAN  |  | Alice   |  |                            |  |                 |  | FICKLIN |  |      |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |  | ADDRESS   |  |                            |  |                 |  |         |  |      |  |          |  |
| YES  |  | 220-01-3716   |  | Mrs. Lydia Callahan, 204 Church Rd, 21136   |  | Reisterstown, Md.   |  |                            |  |                 |  |         |  |      |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per item 18a, 18b, and 18c)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a)   |  | DUE TO (b) AS A CONSEQUENCE OF (c)  |  | DUE TO (d) AS A CONSEQUENCE OF (e)  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                     |  |                            |  |                 |  |         |  |      |  |          |  |
| 5570<br>Massive pulmonary embolism   |  | Thrombosis sub. mesenteric art.   |  | infarct of small intestine  |  |   |  |                            |  |                 |  |         |  |      |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |   |  |                            |  |                 |  |         |  |      |  |          |  |
| old vent. myocardial infarct   |  |   |  |   |  |   |  |                            |  |                 |  |         |  |      |  |          |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE INDICES USED<br>IN CERTIFYING CAUSE OF DEATH?     |  |                            |  |                 |  |         |  |      |  |          |  |
| 11/2/80  |  | MESENTERIC THROMBOSIS   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                            |  |                 |  |         |  |      |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  | 21d. LOCATION<br>CITY OR TOWN                                       |  |                            |  |                 |  |         |  |      |  |          |  |
|  |  | P.M. 19   |  |   |  | COUNTY  |  |                            |  |                 |  |         |  |      |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>CITY OR TOWN   |  | COUNTY  |  |                            |  |                 |  |         |  |      |  |          |  |
|  |  |   |  |   |  |   |  |                            |  |                 |  |         |  |      |  |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/1/80 to 11/3/80, and that in my (our) opinion death occurred on the date and hour and from the cause stated above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE  |  | DEGREE  |  | 22c. DATE SIGNED  |  |                            |  |                 |  |         |  |      |  |          |  |
|  |  | T. JAYAKUMAR  |  | MD  |  | 11/3/80   |  |                            |  |                 |  |         |  |      |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS  |  | 22f. LOCATION   |  | 22g. DATE REC'D. BY REGISTRAR                                       |  | 22h. REGISTRAR'S SIGNATURE |  |                 |  |         |  |      |  |          |  |
| T. JAYAKUMAR   |  | NORTH CHARLES GEN. HOSP.<br>28th ST. BALT.  |  | BALTIMORE   |  | NOV 5 1980  |  | Loring Byers               |  |                 |  |         |  |      |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN                                       |  | COUNTY                     |  | STATE           |  |         |  |      |  |          |  |
| Burial   |  | 11-5-80   |  | Gardens of Faith  |  | Baltimore   |  |                            |  | Md.             |  |         |  |      |  |          |  |
| 24. FUNERAL DIRECTOR   |  | NAME  |  | ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR                                       |  | 25b. REGISTRAR'S SIGNATURE |  |                 |  |         |  |      |  |          |  |
| Loring Byers Chapel  |  | 8728 Liberty Rd. Randallstown, Md. 21133  |  |   |  | NOV 5 1980  |  | Loring Byers               |  |                 |  |         |  |      |  |          |  |

1443A

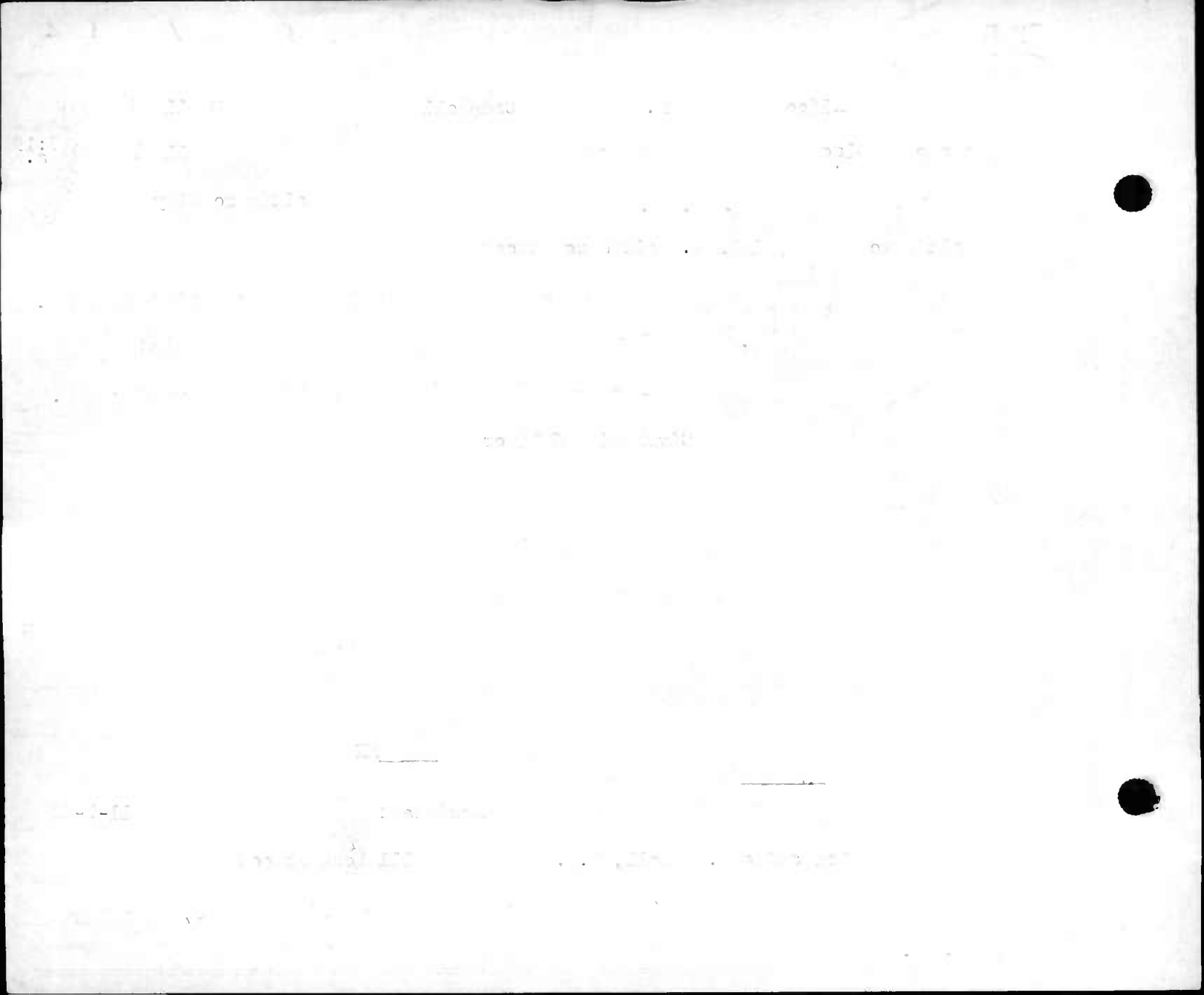
1443B



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                         |   |  |   |   |  |  |   |  | REG. NO. 27912 |  |
|--|-------------------------|---|--|---|---|--|--|---|--|----------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Alice M. Campbell</b>  |                         |   |  |   |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>11 6 19 80</b> |  | 2b. HOUR<br><b>M</b>  |  |                |  |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>Black</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 30 43</b>  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>37 YRS.</b> | IF UNDER 1 YR.<br>MONTHS DAYS<br><b></b>  | IF UNDER 24 HRS.<br>HOURS MIN.<br><b></b> | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>11 7 19 80</b>  |  | 2d. HOUR<br><b>7:19 a.m.</b>  |  |                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |   |  |                |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1825 W. Baltimore Street</b> |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |                         |   |  |   |   |  |  |   |  |                |  |
| 13a. STATE<br><b>Maryland</b>  |                         | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>              |  | 13e. STREET ADDRESS<br><b>1825 West Baltimore St.</b>                               |  |                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John W. Taylor</b>  |                         |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Emma Alston</b>   |   |  |  |   |  |                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |                         | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>216-42-6277</b>   |  | 17. INFORMANT ADDRESS<br><b>Annie Hardy 2924 Winchester St.</b>   |   |  |  |   |  |                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>5715</b> IMMEDIATE CAUSE (a) <b>Cirrhosis of Liver</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____   |                         |   |  |   |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____   |                         |   |  |   |   |  |  |   |  |                |  |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |   |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |   |  |  |   |  |                |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |   |  |                |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |   |  |   |   |  |  |   |  |                |  |
| ACTUAL SIGNATURE <i>Margarita A. Korell</i>  |                         |   |  | TITLE (SPECIFY)<br><b>Assistant</b>   |   | MEDICAL EXAMINER   |  | DATE SIGNED <b>11-7-80</b>  |  |                |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>   |                         |   |  | ADDRESS <b>111 Penn Street</b>  |   |  |  |   |  |                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |                         | 23b. DATE<br><b>11/12/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Memorial Park</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co., Maryland</b>                                 |  |   |  |                |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H 1101 East North Avenue</b>   |                         |   |  | 25a. DATE REC'D BY REGISTRAR <b>NOV 10 1980</b> 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>   |   |  |  |   |  |                |  |





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 27913

FOR  
1 - STATE  
REGISTRAR

REG. NO.

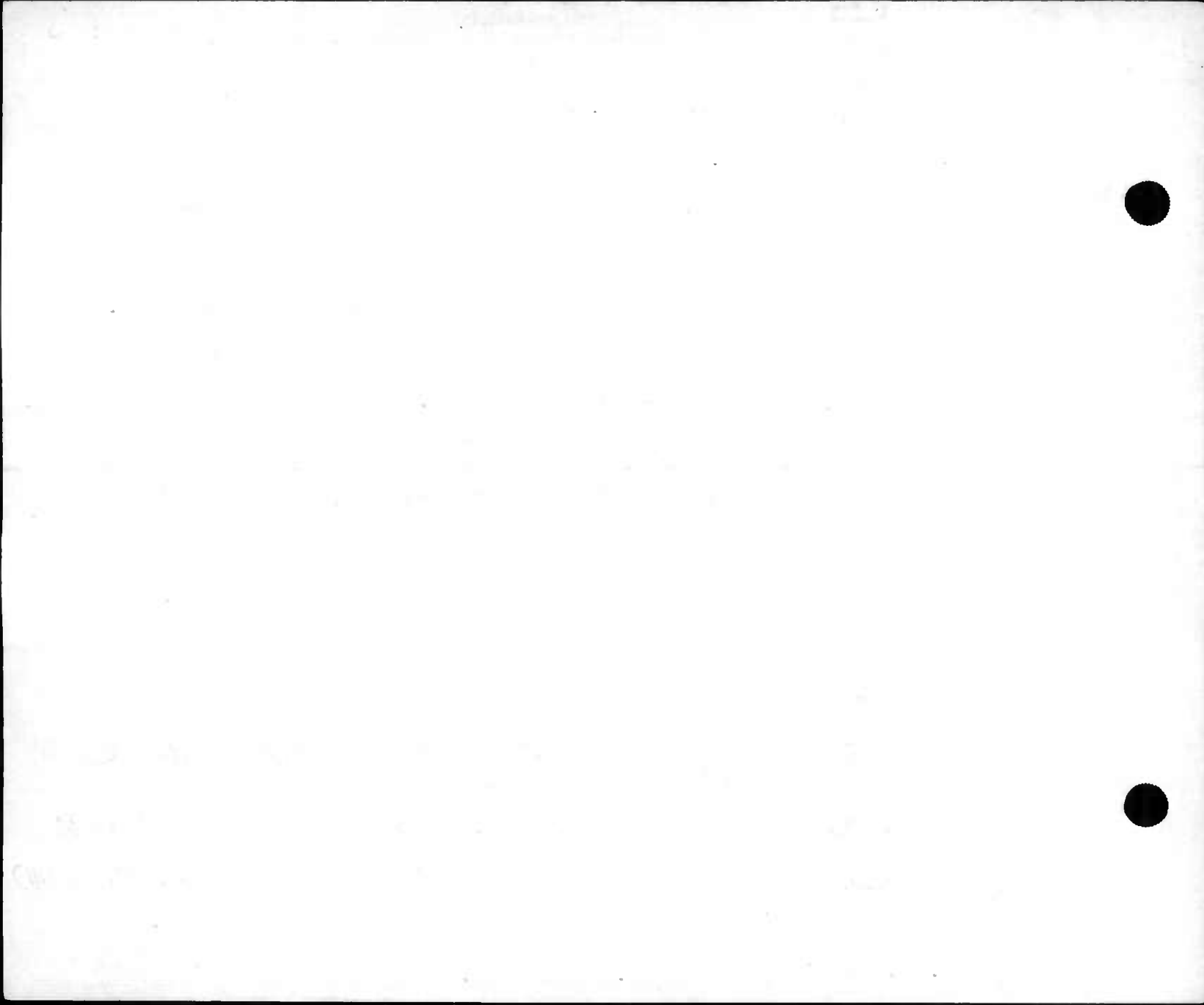
|   |  |   |  |  |  |   |   |  |   |                              |  |
|---|--|---|--|--|--|---|---|--|---|------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>EARL S. CAMPBELL  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 14 1980                |  | 2b. HOUR<br>M  |   |   |  |   |                              |  |
| 3 SEX<br>Male   |  | 4 RACE<br>Negro   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>1 2 22  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>58 YRS.                                 |   | IF UNDER 1 YEAR<br>MONTHS DAYS   |   | IF UNDER 24 HRS<br>HOURS MIN |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                 |   |  |   |                              |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Provident Hospital |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)          |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |                              |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE MD  |  |   | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>1646 Ashburton St. |                              |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Elmo Campbell  |  |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Isabella Wilkens       |  |  |   |   |  |   |                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>Yes   |  |   | 16b. SOCIAL SECURITY NO.<br>220-07-3879                                |  | 17 INFORMANT<br>ADDRESS<br>Doris E. Campbell 1646 Ashburton St.  |   |   |  |   |                              |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest</u><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>ASCVD, S/P MI 9/80</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1hr<br>2min |  |   |  |  |  |   |   |  |   |                              |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:   |  |   |  |  |  |   |   |  |   |                              |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |   |  |   |                              |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |  |   |                              |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>Sept 1980</u> to <u>11/14 1980</u> , that (1) (we) last saw the deceased alive on <u>11/1 1980</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we (I) did not saw the body after death.  |  |   |  |  |  |   |   |  |   |                              |  |
| 22b. SIGNATURE<br><u>Stuart Ross</u>  |  |   | DEGREE<br><u>MD</u>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   | 22c. DATE SIGNED<br><u>11/15/80</u>  |   |                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Stuart Ross</u>   |  |   | 22e. ADDRESS<br><u>10219 S. Doffield Rd, Owings Mills, 21117</u>       |  |  |   |   |  |   |                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>  |  |   | 23b. DATE<br><u>11/18/80</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>King Memorial Park</u>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Baltimore Co. MD</u>                           |  |   |                              |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><u>Wm. C. March F/H</u>  |  |   | ADDRESS<br><u>1101 E. North Ave.</u>                                   |  | 25a. DATE REC'D. BY REGISTRAR<br><u>NOV 19 1980</u>  |   | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |  |   |                              |  |

BP  
DHMH-16 20M  
(VRA 15, 4) 7/78

TO HOSPITAL - ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 27914

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>LUCY S. CANAN</b>  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 27, 1980</b>   |  | 2b. HOUR<br><b>3:15A M</b>   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct. 14, 1912</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>4240 Seidel Avenue</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Bookbinder</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Library</b>  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>-----</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Henry Santi</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>-----</b>  |  | 13e. STREET ADDRESS<br><b>4240 Seidel Avenue</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>212-20-5918</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>21206 Delmer Canan 4240 Seidel Avenue Baltimore, Md</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4100 Cardio Pulmonary Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Acute Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Ischemic CAD and Cardiomyopathy</b> |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>-----</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>-----</b>   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>-----</b> P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>-----</b>  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>-----</b>   |  | 21f. LOCATION<br>STREET<br><b>-----</b>   |  | CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/17/80</b> 19 <b>-----</b> to <b>10/17/80</b> 19 <b>-----</b> , that (I) (we) lost saw the deceased alive on <b>10/17/80</b> 19 <b>-----</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Conrad E. Nagle, MD.</b>  |  |  |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>Nov 30, 1980</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Conrad E. Nagle, MD.</b>   |  |  |  | 22e. ADDRESS<br><b>7404 Osler Drive Towson, Md.</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Dec 1, 1980</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Doppel Funeral Homes, Inc.</b>  |  |  |  | ADDRESS<br><b>7110 Belair Road, Baltimore, Md.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 2 1980</b>   |  |

MEDICAL CERTIFICATION

November 27, 1934

Dec. 11, 1935

January 1, 1936

February 1, 1936

March 1, 1936

April 1, 1936

May 1, 1936

June 1, 1936

July 1, 1936

August 1, 1936

September 1, 1936

October 1, 1936

November 1, 1936

December 1, 1936

January 1, 1937

February 1, 1937

March 1, 1937

April 1, 1937

May 1, 1937

June 1, 1937

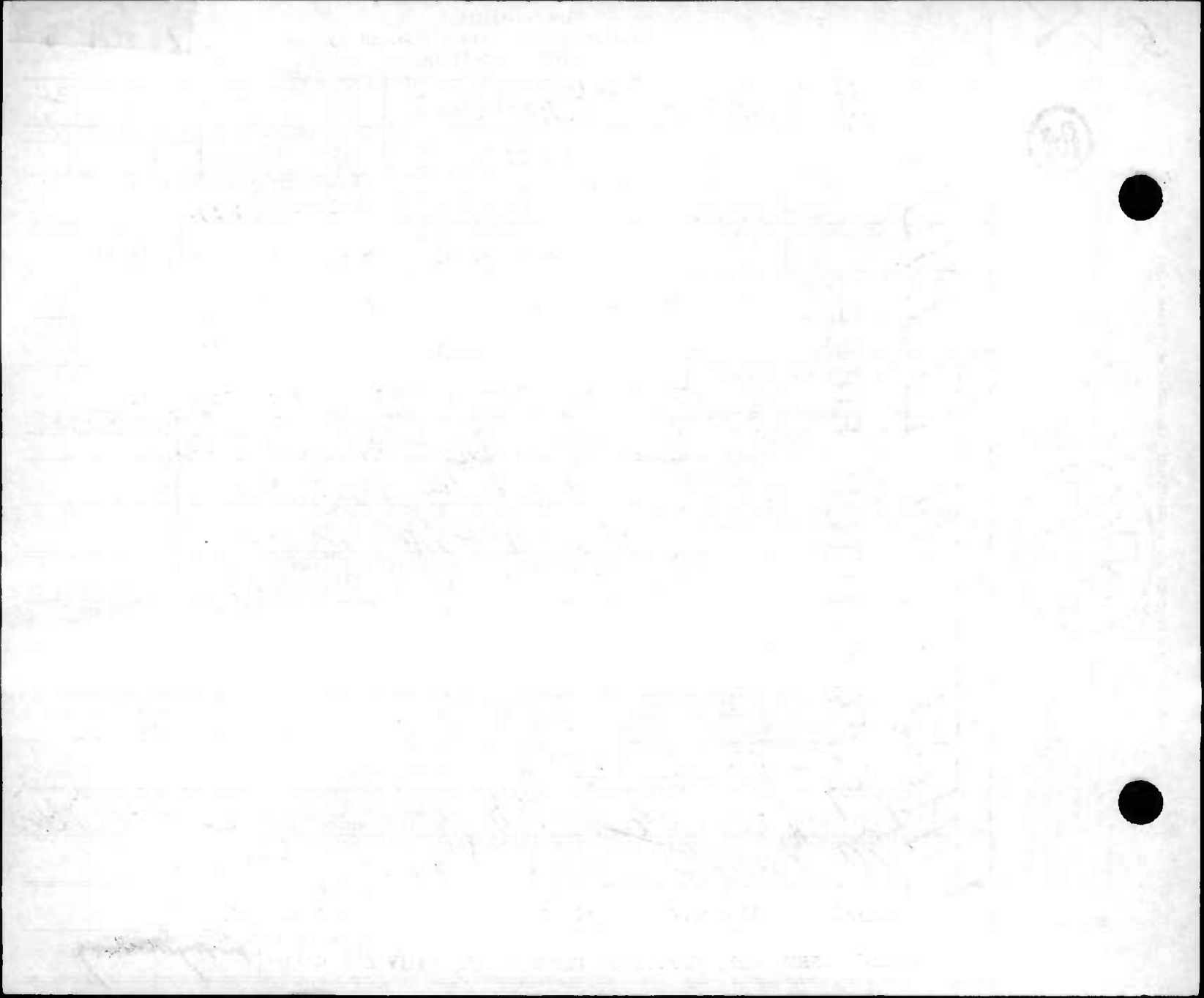
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |   |  |  |  |  |  |
|---|--|---|--|---|--|--|--|--|--|
| CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |  |  |
| 1. FOR STATE REGISTRAR  |  | REG. NO. 80 27915   |  |   |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | Albert Henry MIDDLE Cantow LAST<br><b>ALBERT H CANTOW</b>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>11 25 80</b>  |  | 2b. HOUR<br><b>10 30 P.M.</b>                                |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br><b>5-7-13</b> DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS.  |  | 7. IF UNDER 1 YEAR IF UNDER 2 HRS.<br>MONTHS DAYS HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto.</b> MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Mercy Mercy Hosp.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret. Roller Beth. Steel</b>                         |  | 12b. KIND OF BUSINESS OR INDUSTRY                            |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e. STREET ADDRESS<br><b>2608 Hamilton Ave.</b>             |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>FRANK Frank Cantow</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Agatha Ellasser</b>   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>215-07-4534</b>   |  | 17. INFORMANT<br><b>Cantow</b>  |  | ADDRESS<br><b>2608 Hamilton Ave.</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>VENTRICULAR FIBRILLATION</b><br><b>4149</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>CARDIAC ARREST</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>CONCOMITANT Aortic Disease</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Acute Renal Failure</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (1) this hospital attended the deceased from <b>5/14/80</b> to <b>11/25/80</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did not) view the body after death.   |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>CC Ruck</b>  |  |   |  | 22c. DATE SIGNED<br><b>11/26/80</b>   |  |  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CC Ruck</b>      |  |
| 22e. ADDRESS<br><b>Mercy Hosp.</b>  |  |   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>11-29-80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto., Md.</b>   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J. REX Ruck, Inc.</b>  |  |   |  | ADDRESS<br><b>5305 Harford Rd.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 28 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>             |  |

BP



DHMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| FOR<br>1- STATE<br>REGISTRAR   |  |         |  |  |  |                                    |  |   |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH |  |                                      |  |                |  |       |  |     |  | 27910<br>REG. NO.   |  |              |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |
|--|--|---------|--|--|--|------------------------------------|--|---|--|--|--|--------------------------------------|--|----------------|--|-------|--|-----|--|---|--|--------------|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |         |  | FIRST  |  | MIDDLE                             |  | LAST  |  | 2a. DATE KNOWN<br>OF<br>DEATH  |  |                                      |  | ESTI-<br>MATED |  | MONTH |  | DAY |  | YEAR  |  | 2b. HOUR     |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |
| Aniello  |  |         |  | G  |  | Capecci                            |  | 2a. DATE KNOWN<br>OF<br>DEATH   |  |  |  | ESTI-<br>MATED                       |  | 11             |  | 4     |  | 19  |  | 80  |  | M            |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |
| 3. SEX   |  | 4. RACE |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY) |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS.   |  | 7c. DATE<br>PRONOUNCED<br>DEAD       |  |                |  | MONTH |  | DAY |  | YEAR  |  | 7d. HOUR     |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |
| Male   |  | White   |  | 12 13 22   |  | 57 YRS.                            |  | MONTHS  |  | DAYS   |  | 11 6 19 80                           |  |                |  | 11    |  | 6   |  | 19  |  | 80 6:05 P.M. |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)   |  |         |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |                                    |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |                |  |       |  |     |  |   |  |              |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |
| Maryland   |  |         |  | U.S.A.   |  |                                    |  |   |  |  |  | Baltimore City MD                    |  |                |  |       |  |     |  |   |  |              |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                    |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)  |  |  |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY |  |                |  |       |  |     |  |   |  |              |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |
| Baltimore  |  |         |  | 401 S. Clinton Street  |  |                                    |  | Guard   |  |  |  | Md. Pen.                             |  |                |  |       |  |     |  |   |  |              |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |         |  |  |  |                                    |  |   |  | 13d. INSIDE CITY LIMITS?   |  |                                      |  |                |  |       |  |     |  | 13e. STREET ADDRESS   |  |              |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |
| 13a. STATE   |  |         |  |  |  |                                    |  |   |  | 13b. COUNTY  |  |                                      |  |                |  |       |  |     |  | 13c. CITY OR TOWN   |  |              |  |  |  |  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 401 S. Clinton St. |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME  |  |         |  |  |  |                                    |  |   |  | 15. MOTHER'S MAIDEN NAME   |  |                                      |  |                |  |       |  |     |  |   |  |              |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |
| Serafino   |  |         |  |  |  |                                    |  |   |  | Mary Anna  |  |                                      |  |                |  |       |  |     |  | Maresca   |  |              |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |  |         |  |  |  |                                    |  |   |  | 16b. SOCIAL SECURITY NO.   |  |                                      |  |                |  |       |  |     |  | 17. INFORMANT   |  |              |  |  |  |  |  |  |  | ADDRESS   |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |
| yes  |  |         |  |  |  |                                    |  |   |  | 214-16-8140  |  |                                      |  |                |  |       |  |     |  | Mr. Thomas Capecci, 1817 Portship   |  |              |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c).)  |  |         |  |  |  |                                    |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                    |  |                                      |  |                |  |       |  |     |  |   |  |              |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |
| PART I DEATH WAS CAUSED BY:  |  |         |  |  |  |                                    |  |   |  | IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease                        |  |                                      |  |                |  |       |  |     |  |   |  |              |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |
| 4292   |  |         |  |  |  |                                    |  |   |  | DUE TO, OR AS A CONSEQUENCE OF   |  |                                      |  |                |  |       |  |     |  |   |  |              |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the under-<br>lying cause last.   |  |         |  |  |  |                                    |  |   |  | (b)  |  |                                      |  |                |  |       |  |     |  |   |  |              |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |
|  |  |         |  |  |  |                                    |  |   |  | DUE TO, OR AS A CONSEQUENCE OF   |  |                                      |  |                |  |       |  |     |  |   |  |              |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |
|  |  |         |  |  |  |                                    |  |   |  | (c)  |  |                                      |  |                |  |       |  |     |  |   |  |              |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |         |  |  |  |                                    |  |   |  |  |  |                                      |  |                |  |       |  |     |  |   |  |              |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |         |  |  |  |                                    |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                  |  |                                      |  |                |  |       |  |     |  | 20. AUTOPSY?  |  |              |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |
|  |  |         |  |  |  |                                    |  |   |  |  |  |                                      |  |                |  |       |  |     |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |  |              |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |         |  |  |  |                                    |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR                                    |  |                                      |  |                |  |       |  |     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |              |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |
|  |  |         |  |  |  |                                    |  |   |  | P.M. 19  |  |                                      |  |                |  |       |  |     |  |   |  |              |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |         |  |  |  |                                    |  |   |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)                     |  |                                      |  |                |  |       |  |     |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |              |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |
|  |  |         |  |  |  |                                    |  |   |  |  |  |                                      |  |                |  |       |  |     |  |   |  |              |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |         |  |  |  |                                    |  |   |  |  |  |                                      |  |                |  |       |  |     |  |   |  |              |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |
| ACTUAL<br>SIGNATURE  |  |         |  |  |  |                                    |  |   |  | TITLE (SPECIFY)<br>Assistant   |  |                                      |  |                |  |       |  |     |  | DATE<br>SIGNED  |  |              |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |
| Margarita A. Korell, M.D.  |  |         |  |  |  |                                    |  |   |  | M.D. Assistant   |  |                                      |  |                |  |       |  |     |  | 11-7-80   |  |              |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |  |         |  |  |  |                                    |  |   |  | ADDRESS  |  |                                      |  |                |  |       |  |     |  |   |  |              |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |
| Margarita A. Korell, M.D.  |  |         |  |  |  |                                    |  |   |  | 111 Penn Street  |  |                                      |  |                |  |       |  |     |  |   |  |              |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  |         |  |  |  |                                    |  |   |  | 23b. DATE  |  |                                      |  |                |  |       |  |     |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |              |  |  |  |  |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |
| Burial   |  |         |  |  |  |                                    |  |   |  | 11/8/80  |  |                                      |  |                |  |       |  |     |  | Oaklawn Cemetery  |  |              |  |  |  |  |  |  |  | Baltimore Maryland  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  |         |  |  |  |                                    |  |   |  | ADDRESS  |  |                                      |  |                |  |       |  |     |  | 25a. DATE REC'D. BY REGISTRAR   |  |              |  |  |  |  |  |  |  | 25b. SIGNATURE  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |
| Joseph N. ZANNINO  |  |         |  |  |  |                                    |  |   |  | 263 S. Conkling St.  |  |                                      |  |                |  |       |  |     |  | NOV 10 1980   |  |              |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |

THE UNIVERSITY OF CHICAGO

LIBRARY



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 27917

FOR  
1 - STATE  
REGISTRAR

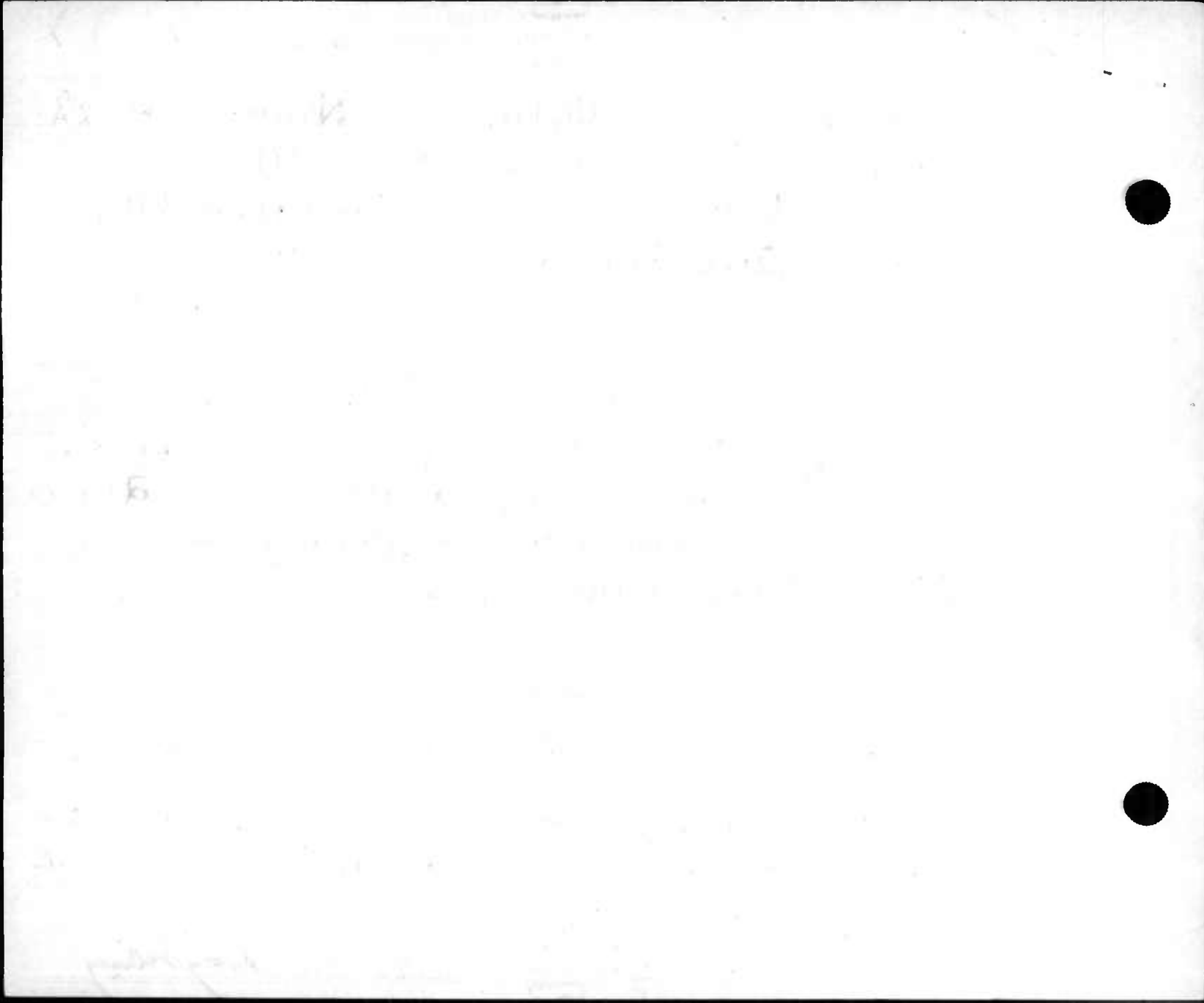
REG. NO.

|  |   |   |  |   |  |
|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Henry Caplan  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 13, 1980                       |   | 2b. HOUR<br>2:15 A.M.  |
| 3. SEX<br>MALE   | 4. RACE<br>Cauc   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>June 23 1909  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VIRGINIA  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                                       |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Sinai Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>PROPRIETOR |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>RESTAURANT  |
| 13a. STATE<br>MARYLAND   |   | 13b. COUNTY   | 13c. CITY OR TOWN<br>BALTIMORE   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>2708 HANSON AVE. #21209   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>ISRAEL CAPLAN  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>REBECCA LEVY   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO   |   | 16b. SOCIAL SECURITY NO.<br>571-12-5112   | 17. INFORMANT<br>MRS. ROSE SAPPORON<br>2708 HANSON AVE. BALTO., MD 21209       |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>respiratory failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>chronic obstructive pulmonary disease</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>immediate</u><br><u>2 weeks</u><br><u>years</u> |   |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>ASCVD, Staph aureus sepsis</u>   |   |   |  |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11-4</u> , 19 <u>80</u> , to <u>11-13</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>11-13</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |   |   |  |   |  |
| 22b. SIGNATURE<br><u>Sheila A. Walker</u>  |   | DEGREE<br>MD  |  | 22c. DATE SIGNED<br>11-13-80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Sheila A. Walker MD   |   | 22e. ADDRESS<br>Sinai Hospital Baltimore Md 21215   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  | 23b. DATE<br>NOV. 13, 1980  | 23c. NAME OF CEMETERY OR CREMATORY<br>OHEL YAKOV  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MARYLAND                                |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>SOL LEVINSON & BROS., INC.<br>6010 REISTERSTOWN RD. BALTO., MD 21215   |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 18 1980  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Shirley McCreedy</u>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |   |  |   |
|---|---|--|---|
| 1- FOR STATE REGISTRAR  |   | 27918  |   |
| 1. DECEASED NAME (TYPE OR PRINT)  |   | 2b. DATE KNOWN OF DEATH  |   |
| ANDREW A. CAPPERELLA, SR.   |   | MONTH DAY YEAR 11 27 80  |   |
| 1. SEX  | 4. RACE   | 5. DATE OF BIRTH   | 6. AGE (IN YEARS)   |
| male  | white   | 12 15 1914   | 65 YRS.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?                                | 8. MARRIED   | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |
| Maryland  | USA   | WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | Baltimore City MD.  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION    | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |
| Baltimore   | Union Memorial Hosp. (DOA)                                  | Delivery   | Grocery   |
| 13a. STATE  | 13b. COUNTY   | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?  |
| Md  | -   | Baltimore  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME   | 15. MOTHER'S MAIDEN NAME                                    | 17. INFORMANT ADDRESS  |   |
| James C. Capperella   | Mary Metrangleo   | Thelma V. Capperella Same  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  | 16b. SOCIAL SECURITY NO.                                    | 17. INFORMANT ADDRESS  |   |
| No  | 212 12 6750   | Thelma V. Capperella Same  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |   |  |   |
| PART 1 DEATH WAS CAUSED BY: Coronary thrombosis   |   |  |   |
| IMMEDIATE CAUSE (a) 4100  |   |  |   |
| DUE TO, OR AS A CONSEQUENCE OF  |   |  |   |
| (b) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |   |  |   |
| (c) DUE TO, OR AS A CONSEQUENCE OF  |   |  |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |   |  |   |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           | 20. AUTOPSY?   |   |
|   |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |   |  |   |
| ACTUAL SIGNATURE  |   | TITLE (SPECIFY)  |   |
| Ann M. Dixon, M.D.  |   | Assistant MEDICAL EXAMINER   |   |
| EXAMINER'S NAME (TYPE OR PRINT)   |   | DATE SIGNED 11-28-80   |   |
| ADDRESS   |   | 111 Penn St.   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   | 23b. DATE   | 23c. NAME OF CEMETERY OR CREMATORY   | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |
| Burial  | 12/1/80   | Lakeview Mem. Park   | Sykesville Carroll Md   |
| 24. FUNERAL DIRECTOR  |   | 25a. DATE REC'D. BY REGISTRAR  | 25b. REGISTRAR'S SIGNATURE  |
| Burgee Funeral Home   |   | DEC 2 1980   |   |



DECS 1980

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |  |   |   |  |                                   |   |   |
|--|--|---|---|--|-----------------------------------|---|---|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 7. DATE KNOWN<br>OF<br>DEATH  |   | 8. MONTH<br>DAY<br>YEAR                    |                                   | 9. HOUR<br>MIN.   |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | 2. DATE KNOWN<br>OF<br>DEATH  |   | 3. MONTH<br>DAY<br>YEAR                    |                                   | 4. HOUR<br>MIN.   |   |
| Abraham Lincoln Carson   |  | 11 10 80  |   | 8:58                                       |                                   | M   |   |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH<br>MONTH DAY YEAR  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)  | 7. IF UNDER 1 YR.<br>MONTHS DAYS           | 8. IF UNDER 24 HRS.<br>HOURS MIN. | 9. DATE<br>PRONOUNCED<br>DEAD   | 10. MONTH<br>DAY<br>YEAR                        |
| Male   | Black  | 8 28 27   | 53 YRS.   |  |                                   | 11 10 80  | 8:58  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |                                   |   |   |
| VA   | USA  |   | Baltimore City, MD  |  |                                   |   |   |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)  | 12b. KIND OF BUSINESS<br>OR INDUSTRY  |  |                                   |   |   |
| Baltimore  | 2815 Walbrook Avenue   |   |   |  |                                   |   |   |
| 13a. STATE   | 13b. COUNTY  | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS                        |                                   |   |   |
| MD   |  | Baltimore   |   | 2815 Walbrook Avenue                       |                                   |   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST  |   |   |  |                                   |   |   |
| Charlie Carson   | Nannie Allen   |   |   |  |                                   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  | 16b. SOCIAL SECURITY NO.   | 17. INFORMANT ADDRESS   |   |  |                                   |   |   |
| Yes  | 224-40-8334  | Mary Carson 2815 Walbrook Ave.  |   |  |                                   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hypertensive cardiovascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                               |  |   |   |  |                                   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.  |  |   |   |  |                                   |   |   |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |   |  |                                   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |  |                                   |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |                                   |   |   |
| 22a. I certify that I took charge of the remains described above, held on<br>death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |   |  |                                   |   |   |
| ACTUAL<br>SIGNATURE <u>Thomas D. Smith</u> TITLE (SPECIFY)<br>M. Deputy Chief MEDICAL EXAMINER   |  |   |   |  |                                   |   | DATE<br>SIGNED 11/10/80                         |
| EXAMINER'S NAME<br>(TYPE OR PRINT) Thomas D. Smith, M.D.   |  |   |   |  |                                   |   | ADDRESS 111 Penn St Balto., MD.                 |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   | 23b. DATE  | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |                                   |   |   |
| Burial   | 11/17/80   | Crownsville VA Cem.   |   | Crownsville MD                             |                                   |   |   |
| 24. FUNERAL DIRECTOR<br>NAME   |  | 25a. DATE REC'D. BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE                 |                                   |   |   |
| Wm. C. March F/H   |  | 1101 E. North Ave.  |   | NOV 12 1980                                |                                   |   |   |

*Handwritten signature*

NOV 13 1980

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 8 0 2 7 9 2 0  |  |
|--|--|--|--|--|--|
| 1- FOR STATE REGISTRAR   |  |  |  | CERTIFICATE OF DEATH   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  |  | 2a. DATE OF DEATH  |  |
| Ada Carter   |  |  |  | 11 7 80  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>U.S.B.  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 20 1897                                |  |
| 7b. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7c. CITIZEN OF WHAT COUNTRY?   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>83 YRS                                      |  |
| 10. CITY OR TOWN OF DEATH<br>CITY  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Union Memorial Hospital |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore CITY MD.                     |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore   |  | 13c. STREET ADDRESS<br>5002 The Alameda  |  |
| 14. FATHER'S NAME<br>James E. Carter   |  | 15. MOTHER'S MAIDEN NAME<br>Ada Nickens  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>212-32-2668  |  | 17. INFORMANT<br>Ella Paul   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiovascular Disease</u><br>4292<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |
| 19a. DATE OF OPERATION<br>10/9/80  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Nonhealing ulcer   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 9 26 19 80, to 11 7 19 80, that (I) (we) lost saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |
| 22b. SIGNATURE<br>R. Patsy Riley   |  | DEGREE<br>MD   |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>R. Patsy Riley  |  | 22e. ADDRESS<br>UNION MEMORIAL HOSPITAL  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>11/10/80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mount Auburn Cemetery                    |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>William C. March Funeral Home Inc  |  | 101 E. North Ave   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland               |  |
| 25a. DATE RECEIVED BY REGISTRAR<br>NOV 10 1980   |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |

CITY

CITY

UNION MEMORIAL HOSPITAL



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

2 7 9 2 1

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |   |   |  |   |  |
|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Bernard John Carter Sr</b>  |   |   | 2a. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>26</b> YEAR <b>80</b>                                |   | 2b. HOUR<br>M  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>Black</b>   | 5. DATE OF BIRTH<br>MONTH <b>9</b> DAY <b>13</b> YEAR <b>22</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>58</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balt. City</b> MD.                                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>4663 Falls Road</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Mover - Self Employed</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br><b>Maryland</b>  |   | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>Baltimore</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>4663 Falls Road</b>  |
| 14. FATHER'S NAME<br>FIRST <b>Junious</b> MIDDLE LAST <b>Carter</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Sophia</b> MIDDLE LAST <b>Rollins</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>215-16-2275</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Helen M. Carter 4663 Falls Road</b>                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Esophagus</b><br><b>1509</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>7 months</b>  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |   |  |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (this hospital) attended the deceased from <b>4/1/80</b> , 19 <b>80</b> , to <b>11/26</b> , 19 <b>80</b> , that (we) last saw the deceased alive on <b>11/16/80</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. |   |   |  |   |  |
| 22b. SIGNATURE<br><b>Kenneth M. Zonies MD</b>  |   | DEGREE  |  | 22c. DATE SIGNED<br><b>11/26/80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KENNETH M. ZONIES</b>  |   | 22e. ADDRESS<br><b>10807 Falls Rd Lutherville Md</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |   | 23b. DATE<br><b>11-29-80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Memorial Pk</b>                                |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore County, Md.</b>   |   | 23e. DATE REC'D. BY REGISTRAR<br><b>DEC 1 1980</b>  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Herbert E. Nutter</b>   |   | ADDRESS<br><b>3035-37 W. North Ave</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 1 1980</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



*Handwritten signature*

DEC 1930

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |   |   |  |   |  |  |                                   |   |
|--|---|---|--|---|--|--|-----------------------------------|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Charles Edward Carter   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 27 80                        |   |  | 2b. HOUR<br>11 30 P.M.   |                                   |   |
| 3. SEX<br>MALE   | 4. RACE<br>CWL  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10-21-09  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS.                             |   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |                                   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>BALTO MD  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.             |   |  |  |                                   |   |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST. AGNES HOSPITAL |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE MARYLAND 13b. COUNTY BALTO 13c. CITY OR TOWN KATONSVILLE  |   |   |  |   |  |  |                                   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>RAYMOND CARTER   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MARTHA CARTER         |   |  |  |                                   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |   |   | 16b. SOCIAL SECURITY NO.<br>215-01-7929                                |   |  | 17. INFORMANT<br>ADDRESS<br>MRS SUSIE CARTER 168 WINTERS LANE  |                                   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Hepato-Renal Syndrome.<br>1539<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Terminal stage of diffuse liver Metastatic Disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Secondary to Colon CA - |   |   |  |   |  |  |                                   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |   |  |   |  |  |                                   |   |
| 19a. DATE OF OPERATION   |   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                                   |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                                   |   |
| 22a. I certify that (1) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (1) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) see the body after death.   |   |   |  |   |  |  |                                   |   |
| 22b. SIGNATURE<br>Dr. Forte  |   |   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                   | 22c. DATE SIGNED  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Forte   |   |   |  |   |  | 22e. ADDRESS<br>St. Agnes Hospital 900 Catox Ave   |                                   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |   |   | 23b. DATE<br>11-31-80  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>ARCADE 405 N. M. PK  |                                   |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Pikesville BALTO MD  |   |   | 23e. DATE REC'D. BY REGISTRAR<br>DEC 2 1980                            |   |  |  |                                   |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Joseph L. Pura 2222 W. NORTH AVE   |   |   |  |   |  |  |                                   |   |

LETTER 350 171

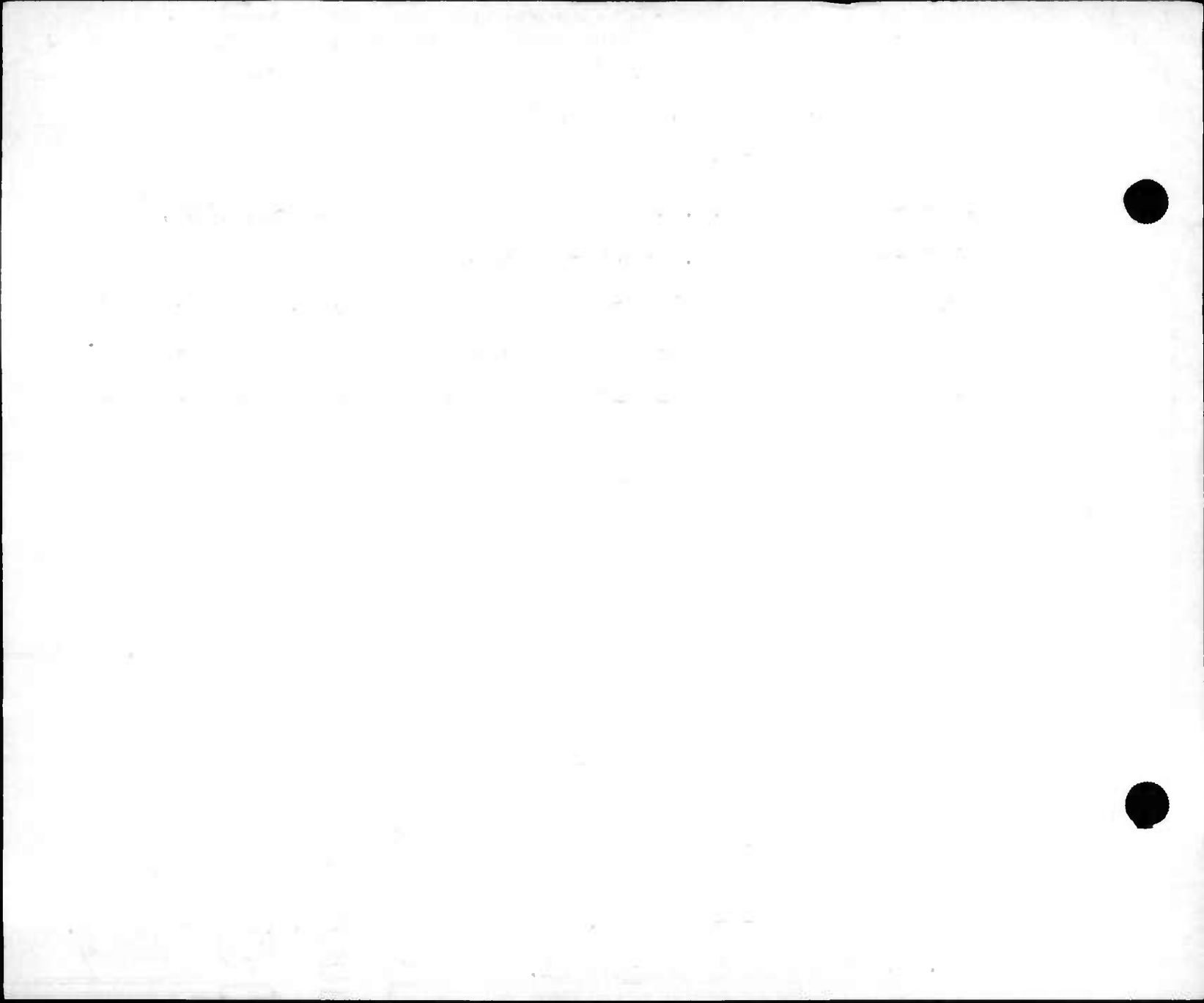
LETTER 350 171

LETTER 350 171

LETTER 350 171

BP \_\_\_\_\_  
DHMH-16 20M  
(VRA 15.4) 7/78

| STATE OF MARYLAND   |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  | 8027923   |  |
|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  | CERTIFICATE OF DEATH   |  | REG. NO.  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | 2a. DATE OF DEATH  |  | 2b. HOUR  |  |
| James S. Carter   |  | 11 3 80  |  | M   |  |
| 3 SEX   |  | 4 RACE   |  | 5 DATE OF BIRTH   |  |
| Male  |  | Black  |  | 5 MONTH DAY YEAR  |  |
|   |  |  |  | 5 24 36   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| S. Carolina   |  | U.S.A.   |  | 9 BALTIMORE CITY OR COUNTY OF DEATH   |  |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |
| Baltimore   |  | 3729 W. Garrison Avenue  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  |
| Maryland  |  |  |  | Baltimore   |  |
| 14 FATHER'S NAME  |  | 15 MOTHER'S MAIDEN NAME  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |
| Adja  |  | Emma   |  | No  |  |
| 17 INFORMANT  |  | 18a. SOCIAL SECURITY NO.   |  | 18b. ADDRESS  |  |
| Emma House  |  | 251-56-2446  |  | 4629 Reisterstown Road  |  |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY   |  | 20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |
| 4029 IMMEDIATE CAUSE (a) Myocardial insuff.   |  |  |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last   |  |  |  |   |  |
| 21. DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |  |
| 22. DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/29/80 to 19/74, that (I) (we) lost saw the deceased alive on 4/29/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE J. Shoro J. M.D.  |  | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) SPBOROTSKY  |  | 22e. ADDRESS 4774 Park Heights Ave 21215   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial  |  | 23b. DATE 11-8-80  |  | 23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn   |  |
| 24. FUNERAL DIRECTOR NAME Chas. A. Rice FSPA 1300 Entaw Pl.   |  | 24b. DATE REC'D. BY REGISTRAR NOV 7 1980   |  | 24c. REGISTRAR'S SIGNATURE  |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR JENIAR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                         |  |  |  |   |   |   |                             | REG. NO. 27924   |  |
|--|--|-------------------------|--|--|--|---|---|---|-----------------------------|--|--|
| 1- FOR STATE REGISTRAR   |  |                         |  |  |  |   |   |   |                             |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Jerome A. Carter</b>  |  |                         |  |  |  |   | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>11 15 1980</b> |   | 2b. HOUR<br><b>12:30 AM</b> |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Black</b> |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>9 21 68</b>  |  | 6. AGE (IN YEARS) LAST BIRTHDAY YRS<br><b>12</b>                      |   | IF UNDER 1 YR. MONTHS DAYS<br><b></b>   |                             | IF UNDER 24 HRS. HOURS MIN.<br><b></b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                             | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sinai Hospital</b> |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b></b>  |                             | 12b. KIND OF BUSINESS OR INDUSTRY<br><b></b>                                     |  |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>Maryland</b>   |  |                         |  | 13b. COUNTY<br><b></b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                 |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                             | 13e. STREET ADDRESS<br><b>2886 W. Garrison Avenue</b>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Roosevelt Carter</b>   |  |                         |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Joyce Davis</b>      |   |   |                             |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  |                         |  | 16b. SOCIAL SECURITY NO.<br><b></b>  |  | 17. INFORMANT ADDRESS<br><b>Joyce L. Carter 2886 W. Garrison Ave.</b> |   |   |                             |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY: <b>Multiple Injuries</b><br>IMMEDIATE CAUSE (a) <b>8147</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b></b><br>(c) <b></b><br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF  |  |                         |  |  |  |   |   |   |                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b></b>                          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):<br><b></b>   |  |                         |  |  |  |   |   |   |                             |  |  |
| 19a. DATE OF OPERATION<br><b></b>  |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?<br><b></b>   |  |   |   |   |                             | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br><b>11:30 P.M. 11 14 19 80</b>  |  |                         |  | 21b. TIME OF INJURY HOUR MONTH DAY YEAR<br><b>11:30 P.M. 11 14 19 80</b>   |  |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)<br><b>subject was pedestrian struck by auto</b>                               |                             |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK<br><b></b>  |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>street</b>   |  |   |   | 21f. LOCATION CITY OR TOWN COUNTY STATE<br><b>5200 blk. Park Heights Ave., Baltimore, Md.</b>   |                             |  |  |
| 22a. I certify that I took charge of the remains described above, held on <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input type="checkbox"/> <b>Accident</b> <input checked="" type="checkbox"/> <b>Suicide</b> <input type="checkbox"/> <b>Homicide</b> <input type="checkbox"/> <b>Undetermined manner</b> <input type="checkbox"/> . |  |                         |  |  |  |   |   |   |                             |  |  |
| ACTUAL SIGNATURE <b>Margarita A. Korell</b>  |  |                         |  |  |  | TITLE (SPECIFY)<br><b>Assistant</b>                                   |   | DATE SIGNED<br><b>11-15-80</b>  |                             |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>   |  |                         |  |  |  | ADDRESS <b>111 Penn Street</b>  |   |   |                             |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |                         |  | 23b. DATE<br><b>11/19/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>      |   |   |                             | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore Baltimore MD</b>         |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br><b>WILLIAM C. MARCH FUNERAL HOME INC. 1101 E. North Avenue</b>  |  |                         |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 19 1980</b>                   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Rafael A. Kelly</b>  |                             |  |  |

100-1000000

100-1000000

100-1000000



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE **80 27925**  
CERTIFICATE OF DEATH

|   |  |  |  |
|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | 2a. DATE OF DEATH  |  |
| FIRST MIDDLE LAST<br><b>MABEL H. CARTER</b>   |  | MONTH DAY YEAR<br><b>November 28, 1980</b>   |  |
| 3. SEX  |  | 2b. HOUR   |  |
| <b>Female</b>   |  | <b>11:55<sup>a</sup> M</b>   |  |
| 4. RACE   |  | 5. DATE OF BIRTH   |  |
| <b>White</b>  |  | MONTH DAY YEAR<br><b>April 19 1894</b>   |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)   |  | 7. CITIZEN OF WHAT COUNTRY?  |  |
| <b>86</b>   |  | <b>U.S.A.</b>  |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |
|   |  | <b>Baltimore City MD.</b>  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                  |  |
| <b>Baltimore</b>  |  | <b>Long Green Nursing Home</b>   |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| <b>Librarian</b>  |  | <b>Public Libr.</b>  |  |
| 13a. STATE  |  | 13b. COUNTY  |  |
| <b>Md.</b>  |  | <b>Balto.</b>  |  |
| 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?   |  |
| <b>Balto.</b>   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 13e. STREET ADDRESS   |  | 14. FATHER'S NAME  |  |
| <b>152 Stevenson Lane</b>   |  | FIRST MIDDLE LAST<br><b>Charles O. Holland</b>   |  |
| 15. MOTHER'S MAIDEN NAME  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |
| <b>Elsie Cooksey</b>  |  | <b>No</b>  |  |
| 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT  |  |
| <b>214-40-5782A</b>   |  | <b>Margaret C. Spencer</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary vascular accident</u><br>4360<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Generalized arteriosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>10 days</u><br><u>3 yrs.</u>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
|   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
|   |  |  |  |
| 21a. INJURY OCCURRED  |  | 21b. TIME OF INJURY  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | HOUR A.M. MONTH DAY YEAR<br><b>11/25 1980</b>  |  |
| 21c. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21d. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |
| <b>11/25 1980</b>   |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>11/23</u> 19 <u>80</u> to <u>11/28</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>11/25</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.  |  | 22b. SIGNATURE   |  |
|   |  | <b>Norman R. Freeman, Jr., M.D.</b>  |  |
| 22c. DATE SIGNED  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |
| <b>12/1/80</b>  |  | <b>Norman R. Freeman, Jr., M.D.</b>  |  |
| 22e. ADDRESS  |  | 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  |
| <b>11 W. 29th St., Balto., Md.</b>  |  | <b>Burial</b>  |  |
| 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |
| <b>12-2-80</b>  |  | <b>Dulaney Valley</b>  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  | 24. FUNERAL DIRECTOR   |  |
| <b>Timonium Balto. Md.</b>  |  | <b>Henry W. Jenkins &amp; Sons Co.</b>   |  |
| 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |  |
| <b>DEC 1 1980</b>   |  | <b>Henry W. Jenkins &amp; Sons Co.</b>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

November 23, 1900

April 10, 1901

White

For 10

Prison City

U.S.A.

As.

Prison City

Prison City

Prison City

Prison City

Prison City

Prison City

Prison City

Prison City

Prison City

Prison City

Prison City

Prison City

Prison City

Prison City

Prison City

Prison City

Prison City

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 8 0 2 7 9 2 6   |  |
|--|--|--|--|---|--|
| 1 - FOR STATE REGISTRAR  |  |  |  | REG. NO.  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>ROBERT L CASEY, Sr  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>11/20/80  |  |
| 2b. HOUR<br>8:41 P.M.  |  | 3. SEX<br>Male   |  | 4. RACE<br>White  |  |
| 5. DATE OF BIRTH MONTH DAY YEAR<br>Mar 25, 1924  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>56 yrs  |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  | 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |   |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL  |  |  |  | 12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE)<br>Security Guard   |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br>Pinderton   |  | 13a. STATE<br>Maryland   |  |   |  |
| 13b. COUNTY<br>--  |  | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>James J Casey   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Mary F. Bell                         |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WW II                   |  | 17. INFORMANT ADDRESS<br>Mrs. Laura Casey-3612 Keystone Ave. 21211  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>HEART FAILURE</u><br>3989<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>CLOTED MITRAL VALVE PROSTHESIS</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>RHEUMATIC HEART DISEASE</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 MONTHS<br>3 MONTHS |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |
| 19a. DATE OF OPERATION<br>11/20/80   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>CLOTED MITRAL VALVE PROSTHESIS |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                            |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)                 |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 20</u> , 19 <u>80</u> , to <u>Nov 20</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>Nov 20</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |
| 22b. SIGNATURE <u>Nicholas A. Sitarski</u> MD  |  |  |  | 22c. DATE SIGNED<br>11/20/80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>NICHOLAS A. SITARSKI MD   |  |  |  | 22e. ADDRESS<br>THE JOHNS HOPKINS HOSPITAL  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>11/25/80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Maryland Vet. Cemetery  |  |
| 23d. LOCATION<br>Crownsville, Maryland   |  | 23e. STATE   |  |   |  |
| 24. FUNERAL DIRECTOR<br>A. Alan Eitz Funeral Home 3818 Roland Ave.   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 2 1980   |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>Robert A. Eitz</u>  |  |  |  |   |  |

A. Alan "ette" Funeral Home 3814 Roland ave.

DECE 1980

Burial 11/25/80 Maryland Nat. Cemetery, Crownsville, Maryland

Yes WA 11

216-16-0747

Mrs. Laura Casey-312 Keystone Ave. 21211

Laura J. Casey

Mary J. 211

3015 Keystone Ave. (21211)

Baltimore

x

Security Guard Station

Virginia

U.S.A.

x

Mar 25, 1981

50 yrs

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

27927

|   |  |  |  |   |   |  |   |   |   |   |  |
|---|--|--|--|---|---|--|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST: Peter MIDDLE: T. LAST: Cento  |  |  | 2a. DATE OF DEATH<br>MONTH: 11 DAY: 2 YEAR: 80                         |   | 2b. HOUR<br>6:55 P M                              |  |   |   |   |   |  |
| 3. SEX<br>M   |  | 4. RACE<br>W   |  | 5. DATE OF BIRTH<br>MONTH: Oct. DAY: 23 YEAR: 1907  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>73 YRS  |   | IF UNDER 1 YEAR<br>MONTHS: DAYS: HOURS: MIN.  |   | IF UNDER 24 HRS<br>HOURS: MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |   |   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Union Memorial Hospital |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Salesman - Wholesale Food  |   |   |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br>Maryland  |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br>Baltimore                    |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br>26 Merrymount Road |   |  |
| 14. FATHER'S NAME<br>FIRST: Thomas MIDDLE: LAST: Cento  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST: Maria MIDDLE: LAST: Cimino          |   |   |  |   |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212 10 0943 |   | 17. INFORMANT<br>Mrs. Evelyn V. Cento             |  |   | ADDRESS<br>Same   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiogenic Shock</u><br>4279<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <u>Ischemic Bowel</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) <u>Ventricular Arrhythmia</u> |  |  |  |   |   |  |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>24 hrs<br>24 hrs<br>24 hrs |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |   |   |  |   |   |   |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |   |   |  |
| 22a. I certify that (X) (this hospital) attended the deceased from 11/2/80 to 11/2/80, that (we) last saw the deceased alive on 11/2/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.         |  |  |  |   |   |  |   |   |   |   |  |
| 22b. SIGNATURE<br>Maria Stack MD  |  |  |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br>11/2/80   |   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MARIA STACK  |  |  |  |   |   | 22e. ADDRESS<br>Union Memorial Hospital  |   |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation   |  |  | 23b. DATE<br>11/4/80   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Green Mount |  | 23d. LOCATION<br>CITY OR TOWN: Baltimore, COUNTY: Maryland STATE                                |   |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME: Henry W. Jenkins & Sons Co.<br>ADDRESS: 4905 York Road Balto., Md. 21212  |  |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 6 1980  |   | 25b. REGISTRAR'S SIGNATURE<br>D. J. McCreedy  |   |   |  |

25

AEU

Indigene - Indigene, nein!

oc 1 afk=low n m e f

Editorial

● **truncation**

Conto

Sign

Site 10 0648 Mrs. Evelyn V. Condo Same

04

YORK ROAD, BOSTON, MASS. 02115  
HENRY W. JENNINGS & SONS CO.  
CONNECTION 11-4435 (TOLL FREE)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 7 9 2 8

FOR  
1. STATE  
REGISTRAR

REG. NO.

|   |   |  |   |  |   |  |  |
|---|---|--|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>SMITH W. CHANCE</b>   |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 29 80</b>  |  |   | 2b. HOUR<br><b>10<sup>2</sup> A. M.</b>  |  |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>WHITE</b>                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 10 1917</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b> YRS.                              |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD                  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(GIVE STREET ADDRESS)<br><b>Baltimore City Hospital</b> |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Welder</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Steel</b>              |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   |   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Dundalk</b>   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Adolphus Chance</b>  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ella Moffett</b>  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW II</b>  |   | 17. INFORMANT<br><b>Michael D. Chance - Balto. MD. 21222</b>                   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiac arrest</b><br><b>5698</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>respiratory insufficiency hrs.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>pneumonia</b><br><b>days</b> |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>recurrent squamous cell carcinoma</b>   |   |  |   |  |   |  |  |
| 19a. DATE OF OPERATION<br><b>11/24/80</b>   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>bowel perforation</b>                                       |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/29</b> 19 <b>80</b> , to <b>11/29</b> 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>11/29</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) did (did not) view the body after death.   |   |  |   |  |   |  |  |
| 22b. SIGNATURE<br><b>Julia H. Yeo</b>   |   |  |   | DEGREE<br><b>MD</b>  |   | 22c. DATE SIGNED<br><b>11/29/80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JULIA H. YEO</b>  |   |  |   | 22e. ADDRESS<br><b>Balto. City Hosp.</b>                                       |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |   | 23b. DATE<br><b>12/4/1980</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Crownsville Vet.</b>                  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Crownsville A.A. Maryland</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Duda-Ruck, Inc.</b>  |   |  |   | ADDRESS<br><b>7922 Wise Avenue Dundalk, MD. 21222</b>                          |   | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 2 1980</b>   |  |
|   |   |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Robert M. Brady</b>                           |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



\_\_\_\_\_



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |   |  |   |  |                            |   |  | 8 0 2 7 9 2 9 |
|---|--|--|---|--|---|--|----------------------------|---|--|---------------|
| 1. FOR STATE REGISTRAR  |  |  |   |  |   |  |                            |   |  | REG. NO.      |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST <u>William</u> MIDDLE <u>M. B.</u> LAST <u>Chandler</u><br><u>William M. B. Chandler Sr.</u>  |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><u>11 / 14 / 80</u> |  | 2b. HOUR<br><u>7:30 AM</u> |   |  |               |
| 3. SEX<br><u>Male</u>   |  | 4. RACE<br><u>Caucasian</u>  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><u>09 21 09</u>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>71</u> YRS.  |                            | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.   |  |               |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>Minnesota</u>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>         |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Baltimore City</u> MD   |                            |   |  |               |
| 10. CITY OR TOWN OF DEATH<br><u>Baltimore</u>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>Baltimore City Hospital</u> |   |  |   | 12a. USUAL OCCUPATION (TYPE SHOW MOST OF WORKING LIFE)<br><u>Signal Maintainer</u>                                   |                            | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>B&amp;O Railroad</u>  |  |               |
| 13a. STATE<br><u>Maryland</u>   |  | 13b. COUNTY<br><u>Baltimore</u>  |   | 13c. CITY OR TOWN<br><u>Dundalk</u>  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                         |                            | 13e. STREET ADDRESS<br><u>3127 Liberty Parkway</u>  |  |               |
| 14. FATHER'S NAME FIRST <u>William</u> MIDDLE LAST <u>Chandler</u>  |  |  | 15. MOTHER'S MAIDEN NAME FIRST <u>Emily</u> MIDDLE LAST <u>Mohn</u> |  |   | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>Yes</u> (IF YES, GIVE WAR OR DATES) <u>WW II</u> |                            |   |  |               |
| 16a. SOCIAL SECURITY NO.<br><u>255-03-4506</u>  |  |  | 17. INFORMANT<br><u>Juanita E. Chandler-Balto.</u>                  |  |   | 17b. ADDRESS<br><u>3127 Liberty Parkway Md. 21222</u>  |                            |   |  |               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio Pulmonary Arrest</u><br><u>4275</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Shock</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |  |   |  |                            |   |  |               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |   |  |   |  |                            |   |  |               |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |               |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |                            |   |  |               |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |  |                            |   |  |               |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/14/80</u> , 19 <u>80</u> , to <u>11/14/80</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>11/14/80</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |  |   |  |                            |   |  |               |
| 22b. SIGNATURE<br><u>M. Welinsky</u>  |  |  |   | DEGREE<br><u>M.D.</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |  |                            | 22c. DATE SIGNED<br><u>11/14/80</u>   |  |               |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>M. Welinsky</u>   |  |  |   | 22e. ADDRESS   |   |  |                            |   |  |               |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>  |  | 23b. DATE<br><u>11/17/80</u>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Moreland Mem. Park</u>  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><u>Baltimore Maryland</u>   |                            |   |  |               |
| 24. FUNERAL DIRECTOR NAME<br><u>Duda-Ruck, Inc.</u>   |  |  |   | ADDRESS<br><u>7922 Wise Avenue Dundalk, Md. 21222</u>  |   | 25a. DATE REC'D. BY REGISTRAR<br><u>NOV 18 1980</u>  |                            | 25b. REGISTRAR'S SIGNATURE<br><u>Ruby Helms</u>   |  |               |

MEDICAL CERTIFICATION

4211 BP

DHMH - 16 50M 7/77  
(VR A 15 (4))

1947

PO 12 PO 10121123

5103

2232 Wisconsin Avenue, N.W., Washington, D.C. 20007  
 NOV 8 1960

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

2 7 9 3 0

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|   |   |   |   |  |  |
|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MMX MILDRED CHANEY</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11-2-80</b>                           |  | 2b. HOUR<br><b>2:50AM</b>  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 1 1911</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Unknown</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                        |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Church Home Hosp.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret.</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br><b>Md</b>   |   |   | 13b. COUNTY<br><b>Balto</b>   | 13c. CITY OR TOWN<br><b>Balto</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>                 |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>962 13 2702</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Medical Records</b>                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>CARDIO RESPIRATORY ARREST</b><br><b>4292</b><br>IMMEDIATE CAUSE (a) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CARDIOVASCULAR ACCIDENT</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |   |   |   |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>10-30 80</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)           |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) this hospital attended the deceased from <b>11-2 80</b> to <b>11-2 80</b> that (I) (we) lost saw the deceased <b>above</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.  |   |   |   |  |  |
| 22b. SIGNATURE<br><b>V. Balakrishnan</b>  |   |   |   | 22c. DATE SIGNED<br><b>11-2-80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. V. BALAKRISHNAN, MD.</b>  |   |   |   | 22e. ADDRESS<br><b>CHURCH HOSPITAL CORPORATION<br/>100 N. BROADWAY BALTO., MD. 21231</b> |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |   | 23b. DATE<br><b>11-5-80</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Calvary Cem.</b>                            |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>A. A. CO Md</b>  |   | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Brown/Thompson Funeral Home 1913 W. Balto.</b>   |   |  |  |
| 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 3 1980</b>  |   |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |

MEDICAL CERTIFICATION

110

and 1101

1101

1101

1101

1101

1101

1101

1101

1101

1101

1101

1101

1101

1101

1101

1101

1101

1101

1101

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 7 9 3 1

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Elsie F. Chapman</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11-26-80</b>                               |  | 2b. HOUR<br><b>4:15 P.M.</b>                         |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Aug. 20, 1891</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>89 YRS.</b>  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>                                      |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Mercy Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b> |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>City</b>   | 13d. INSIDE CITY LIMITS?<br><b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>549-76-8339</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Paul Bailey Leonardtown, Md.</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4275 Sudden Cardio-Pul arrest</b><br>IMMEDIATE CAUSE (a) <b>Debilitation</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b)<br>(c)<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                         |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>S. Ackley</b>  |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>11/26/80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>S. ACKLEY</b>   |  | 22e. ADDRESS<br><b>Mercy Hospital Baltimore, MD</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>11-29-80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Metropolitan</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Archart Funeral Home</b>   |  | ADDRESS<br><b>La Plata, Md.</b>   |  | 25a. DATE RECD. BY REGISTRAR<br><b>DEC 8 1980</b>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  | 25c. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |  |  |

MEDICAL CERTIFICATION

BP

STANDARD TIME  
1934 - 1935  
1936 - 1937

1934 1 1937

80  
Bal Elmore  
Hawthorne  
X  
Unknown

1934-1935  
1936-1937

1938-1939  
1940-1941  
1942-1943  
1944-1945  
1946-1947  
1948-1949  
1950-1951  
1952-1953  
1954-1955  
1956-1957  
1958-1959  
1960-1961  
1962-1963  
1964-1965  
1966-1967  
1968-1969  
1970-1971  
1972-1973  
1974-1975  
1976-1977  
1978-1979  
1980-1981  
1982-1983  
1984-1985  
1986-1987  
1988-1989  
1990-1991  
1992-1993  
1994-1995  
1996-1997  
1998-1999  
2000-2001  
2002-2003  
2004-2005  
2006-2007  
2008-2009  
2010-2011  
2012-2013  
2014-2015  
2016-2017  
2018-2019  
2020-2021  
2022-2023  
2024-2025

1934 1 1937  
1938 1 1941  
1942 1 1945  
1946 1 1949  
1950 1 1953  
1954 1 1957  
1958 1 1961  
1962 1 1965  
1966 1 1969  
1970 1 1973  
1974 1 1977  
1978 1 1981  
1982 1 1985  
1986 1 1989  
1990 1 1993  
1994 1 1997  
1998 1 2001  
2002 1 2005  
2006 1 2009  
2010 1 2013  
2014 1 2017  
2018 1 2021  
2022 1 2025

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 7 9 3 2

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |   |   |   |                   |   |  |   |  |                               |  |
|---|--|---|---|---|-------------------|---|--|---|--|-------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Peggy Violena Chase         |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 10 1980 |   | 2b. HOUR<br>8:30A |   |  |   |  |                               |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Black  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 25 1929  |                   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>50 YRS.  |  | 7. UNDER 1 YEAR<br>MONTHS DAYS<br>HOURS MIN       |  | 7. UNDER 24 HRS.<br>HOURS MIN |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                                       |  |   |  |                               |  |
| 10. CITY OR TOWN OF DEATH<br>Balto.   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3117 Phelps Lane |   |   |                   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>seamstress                  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Loundon Town |  |                               |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  |   |   |   |                   |   |  |   |  |                               |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY   |   | 13c. CITY OR TOWN<br>Balto  |                   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>3117 Phelps Lane           |  |                               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Edgar W. Henry                                |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ada Pinder   |                   |   |  |   |  |                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No              |  |   |   | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>213 22 8623   |                   | 17. INFORMANT<br>ADDRESS<br>William R Chase PO Box 735 Ithaca N. Y. 14850                       |  |   |  |                               |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

1519  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Metastatic gastric  
carcinoma

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last<br>saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |

22b. SIGNATURE

DEGREE

ATTENDING  
PHYSICIAN ☐ MEDICAL  
DIRECTOR ☐ STAFF  
PHYSICIAN ☐

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

STANLEY MORRISON

11 E. Chase Street

|  |  |                       |  |  |  |   |  |
|--|--|-----------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                   |  | 23b. DATE<br>11-15-80 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Union Chapel Cem |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Cordtown Md |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Brown/Thompson F.H. 1913 W. Baltimore St |  |                       |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 14 1980           |  | 25b. REGISTRAR'S SIGNATURE<br>L. J. Kelly                 |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Age 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |   |  |   |  |
|---|--|--|--|--|--|---|--|---|--|---|--|
| 1. STATE REGISTRAR  |  | REG. NO. 80 27933  |  |  |  |   |  |   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST  |  | MIDDLE   |  | LAST  |  | 2a. DATE OF DEATH MONTH DAY YEAR                              |  | 2b. HOUR  |  |
| Viola   |  | Edna   |  | Christ   |  |   |  | 11 24 80  |  | 2:50 PM   |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | IF UNDER 1 YEAR MONTHS DAYS                                   |  | IF UNDER 24 HRS. HOURS MIN.                                 |  |
| Female  |  | White  |  | 02 03 1907   |  | 73  |  |   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |   |  |   |  |
| Maryland  |  | USA  |  |  |  | Baltimore City MD   |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY                           |  |
| Baltimore   |  | 3501 Elmora Avenue   |  |  |  |   |  | Housewife   |  | Homemaking  |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e. STREET ADDRESS   |  |   |  |
| Maryland  |  |  |  | Baltimore  |  |   |  | 3501 Elmora Avenue  |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |  |   |  |   |  |   |  |
| Milton  |  | Pinkerton  |  | Grace  |  | Thompson  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS   |  |   |  |   |  |
| No  |  | 212-74-9739  |  | Ralph W. Christ  |  | 5812 Moores Run Ct.   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Embolism</u>  |  |  |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>seconds</u> |  |
| 4100  |  |  |  |  |  |   |  |   |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic Vascular disease, severe</u>   |  |  |  |  |  |   |  |   |  | 30 yrs  |  |
| (c) <u>paralysis</u>  |  |  |  |  |  |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <u>C.V.A. (Stroke) for 30 yrs. Unable to talk or control self</u>  |  |  |  |  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |   |  |
| MD  |  | No   |  |  |  |   |  |   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |   |  |   |  |
| No  |  | No P.M. 19   |  | No   |  |   |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |   |  |
| No  |  | No   |  |  |  |   |  |   |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>9/8/80</u> to <u>11/24/80</u> , that (2) (we) lost saw the deceased alive on <u>9/8/80</u> , and that (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (we) did not view the body after death. |  |  |  |  |  |   |  |   |  |   |  |
| 22b. SIGNATURE  |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED  |  |   |  |   |  |
| P. Challe M.D.  |  | M.D.   |  |  |  | 11/26/80  |  |   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |  |  |   |  |   |  |   |  |
| P.C. KATHE  |  | 8508 Loch Raven Blvd   |  | 8508 Loch Raven Blvd, Md 21204   |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| Burial  |  | 11/28/80   |  | Zion Luth.Ch.Cem.  |  | Golden Ring Baltimore Md.   |  |   |  |   |  |
| 24. FUNERAL DIRECTOR NAME   |  | ADDRESS  |  | 25a. DATE RECEIVED BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |   |  |
| Lassahn Funeral Home  |  | 7401 Belair Road   |  | NOV 28 1980  |  | [Signature]   |  |   |  |   |  |

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

14

TO : DIRECTOR, FBI (100-441100)  
FROM : SAC, NEW YORK (100-100000)  
SUBJECT: [Illegible]  
RE: [Illegible]

[Illegible body text]

Very truly yours,  
[Illegible Signature]  
Special Agent in Charge

100-441100-100000  
100-100000-100000

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |               |  |   |  |  |  |  |  | REG. NO. 27934   |  |
|--|--|---------------|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |               |  |   |  |  |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) George L. Claiborne Clayborne  |  |               |  |   |  |  |  |  |  | 2b. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> 11 16 1980 |  |
| 3. SEX male  |  | 4. RACE black |  | 5. DATE OF BIRTH MONTH DAY YEAR 2 28 50   |  | 6. AGE (IN YEARS) LAST BIRTHDAY 30 YRS.  |  | IF UNDER 1 YR. MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia   |  |               |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.   |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.                            |  |
| 10. CITY OR TOWN OF DEATH Baltimore  |  |               |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital STU |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Fabric Worker  |  | 12b. KIND OF BUSINESS OR INDUSTRY Warehouse  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |               |  |   |  |  |  |  |  |  |  |
| 13a. STATE md  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN Balto   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS 4107 BONNER Rd Balto, Md   |  |  |  |
| 14. FATHER'S NAME FIRST Charlie MIDDLE LAST Pretlow  |  |               |  | 15. MOTHER'S MAIDEN NAME FIRST Lula Mae MIDDLE LAST Claiborne   |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No  |  |               |  | 16b. SOCIAL SECURITY NO. 228-76-1775  |  | 17. INFORMANT Mrs. Ruth C. Page  |  | ADDRESS 706 33rd St New Port News Va.  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Gun shot wound of head Gun: Unspecified<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c) DUE TO, OR AS A CONSEQUENCE OF   |  |               |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                       |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |               |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |  |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |               |  | 21b. TIME OF INJURY HOUR XX MONTH DAY YEAR 1:10AM 11/ 16 19 80  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2) subject shot   |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>   |  |               |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street  |  | 21f. LOCATION CITY OR TOWN COUNTY STATE 1200BlkWhitelockSt. Baltimore City, MD               |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |               |  |   |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE [Signature]   |  |               |  | TITLE (SPECIFY) Assistant M.D.  |  |  |  | MEDICAL EXAMINER   |  | DATE SIGNED 11/17/80   |  |
| EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.  |  |               |  | ADDRESS 111 Penn Street, Balto. MD 21201  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial   |  |               |  | 23b. DATE 11/22/80  |  | 23c. NAME OF CEMETERY OR CREMATORY Oak Grove B.C. Cem.                                       |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Wakefield, Deserp, Va  |  |  |  |
| 24. FUNERAL DIRECTOR NAME Chatman  |  |               |  | ADDRESS 1701 McCulloch St Balto, Md   |  | 25a. DATE REC'D. BY REGISTRAR 2/2/77   |  | 25b. REGISTRAR'S SIGNATURE [Signature]   |  |  |  |

NOV 12 1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 27935

REG. NO.

|  |  |   |  |   |   |
|--|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ARTHUR EUGENE CLARK</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11-11-80</b>                             |   | 2b. HOUR<br>MIN.<br><b>8<sup>00</sup> A</b>   |
| 3. SEX<br><b>male</b>  | 4. RACE<br><b>NEGRO</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 14 20</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br><b>59</b>  |   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MD.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN THIS FACILITY, GIVE STREET ADDRESS)<br><b>907 Mc DONOUGH St.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Laborer</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>?</b> |
| 13a. STATE<br><b>MD.</b>   |  | 13b. COUNTY<br><b>Balto.</b>  | 13c. CITY OR TOWN<br><b>Balto.</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James Clark</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Gaskins</b>  |  | 13e. STREET ADDRESS<br><b>907 Mc DONOUGH St.</b>  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>218-05-4991</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Rosemary Spencer 6131 Marlboro Rd.</b>                      |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CACWEXIA.</b><br><b>1410</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>METASTATIC CARCINOMA BASE TONGUE.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>STROKE</b> |  |   |  |   |   |
| 19a. DATE OF OPERATION<br><b>5/16/79</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>CARCINOMA TONGUE</b>   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)    |  |   |   |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/78</b> , 19 <b>78</b> , to <b>11/80</b> , 19 <b>80</b> , that (I) (we) last saw the deceased on <b>11/80</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |   |
| 22b. SIGNATURE<br><b>Robert Pineyro</b>  |  | DEGREE<br><b>John Hopkins Hospital</b>  |  | 22c. DATE SIGNED<br><b>11-11-80</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ROBERTO PINEYRO</b>  |  | 22e. ADDRESS<br><b>John Hopkins Hospital</b>  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11-15-80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Cnty</b>                                     |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore MD.</b>   |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Randolph J. Collick 2431 E. Oliver St.</b>   |  |   |   |
| 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 12 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Henry McCreedy</b>   |  |   |   |

THE  
UNITED STATES  
DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT  
WASHINGTON, D. C.

REPORT  
ON THE  
LANDS OF THE  
BUREAU OF LAND MANAGEMENT  
IN THE  
STATE OF ARIZONA  
BY  
J. W. COOPER  
AND  
J. H. COOPER  
1917

1



1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 7 9 3 6

REG. NO.

|   |  |   |   |   |                             |   |  |   |  |   |  |
|---|--|---|---|---|-----------------------------|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>FLORENCE P. CLARKE</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 18, 1980</b> |   | 2b. HOURS<br><b>8:00 AM</b> |   |  |   |  |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 29, 1898</b>  |                             | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>81 YRS.</b>                           |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>81 YRS.</b>   |  | 8. IF UNDER 24 HRS.<br>HOURS MIN.<br><b>81 YRS.</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                             | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>5715 Chinquapin Parkway</b> |   |   |                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Fitter</b>               |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Nothing</b>   |  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |   |   |                             |   |  |   |  |   |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |                             | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>5715 Chinquapin Parkway</b>   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Anton Steitz</b>   |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elizabeth Casselman</b>   |                             |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>218 14 5126</b>   |   | 17. INFORMANT<br><b>Leone Steitz</b>  |                             |   |  | ADDRESS<br><b>Balto., Md.</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Acute Myelogenous Leukemia</b><br>2050<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |   |   |   |                             |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |   |                             |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                             |   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                             |   |  |   |  |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>11/7/80</b> 19 to <b>11/8/80</b> 19, that (I) (we) lost the deceased alive on <b>10/30/80</b> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. |  |   |   |   |                             |   |  |   |  |   |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Thomas Worsley, M.D.</b>  |  |   |   | 22c. ADDRESS<br><b>6505 York Road Balto., Md.</b>   |                             |   |  | 22d. DATE SIGNED<br><b>11/18/80</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>11/21/80</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Balto. National</b>  |                             | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto., Md.</b>                                |  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Henry W. Jenkins &amp; Sons Co.<br/>4905 York Road Balto., Md. 21212</b>   |  |   |   |   |                             | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 20 1980</b>   |  | 25b. SIGNATURE<br><b>[Signature]</b>  |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1.  $\int_0^1 x^2 dx = \frac{1}{3}$

and

1951, 1952, 1953

5

Myself

A3U

4

the 1990s

540 21-11-1982

3715 Chinnaijin Parkway

7577

● **John**

May 1964

eromir[12]



571 Christchurch 5000

notra

スジ、ナ

11-2-21

Copyright

C/4

1958-1959

• 1994 •

12. 12. 12

1 2 3 4

London, U.K.

• • •

1005 York Road, Baltimore, Md. 21212

7. The following are the names of the persons who have been appointed as members of the committee:

6111



\*TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

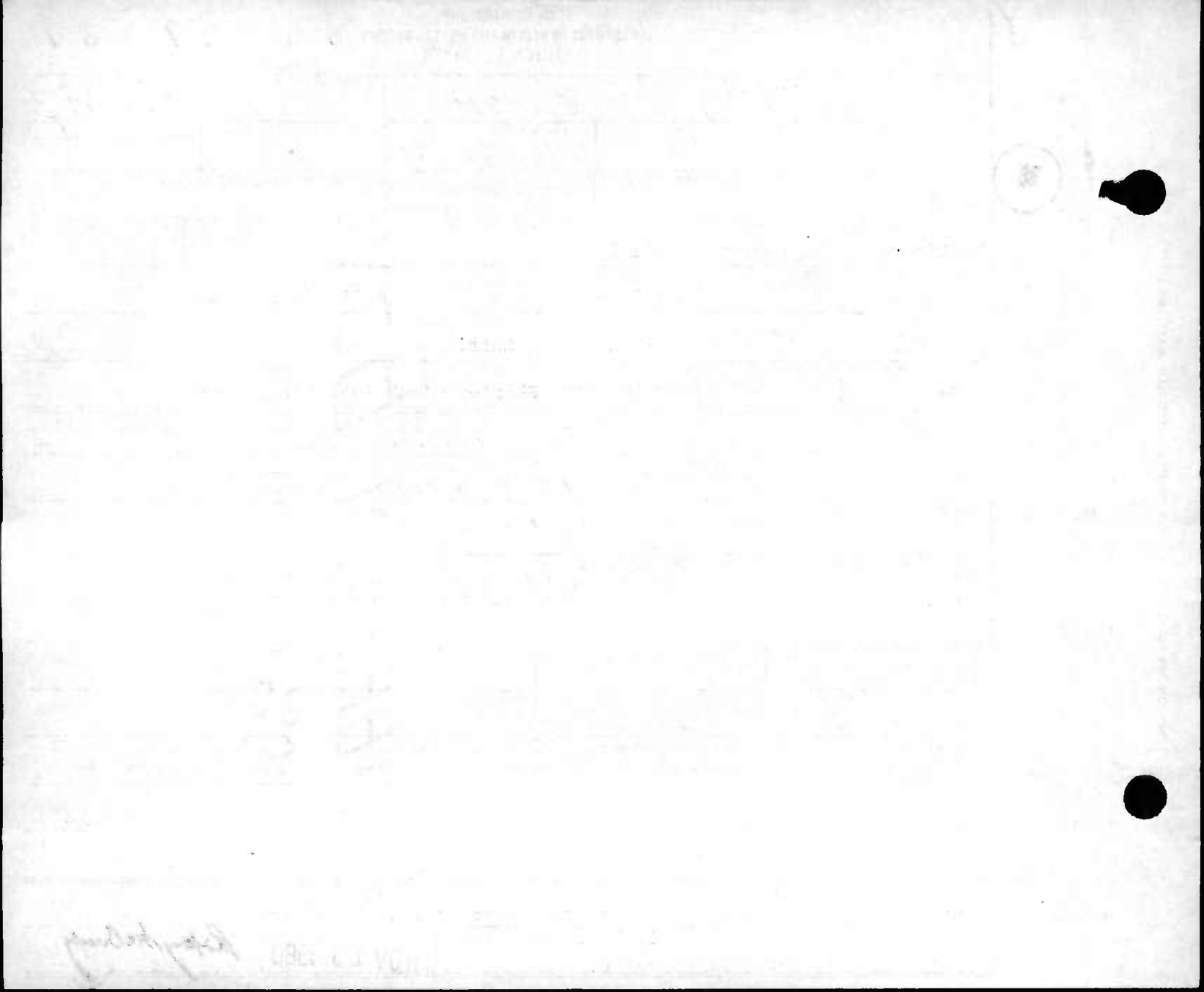
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

2 7 9 3 7

REG. NO.

|   |                     |  |  |  |   |
|---|---------------------|--|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Philip CLASH</b>   |                     | 2a. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>13</b> YEAR <b>80</b>  |  | 2b. HOUR<br><b>8:08 PM</b>   |   |
| 3. SEX<br><b>M</b>  | 4. RACE<br><b>B</b> | 5. DATE OF BIRTH<br>MONTH <b>11</b> DAY <b>19</b> YEAR <b>14</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b> YRS.                              |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |                     | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY</b> MD.                        |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Mercy Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               |   |
| 13a. STATE<br><b>Maryland</b>   |                     | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. STREET ADDRESS<br><b>1451 Kitmore Road</b>                                |   |
| 14. FATHER'S NAME<br>FIRST <b>John</b> MIDDLE <b>Clash</b> LAST <b>Clash</b>  |                     | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Nettie</b> MIDDLE <b>Nettie</b> LAST <b>Nettie</b>  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |                     | 16b. SOCIAL SECURITY NO.<br><b>220-10-6027</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Shirley Clash 1451 Kitmore Road</b>             |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>SEPTIC SHOCK</b><br><b>4360</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>URINARY TRACT INFECTION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>CVA</b> |                     |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>MYOCARDIAL INFARCTION</b>  |                     |  |  |  |   |
| 19a. DATE OF OPERATION  |                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |                     | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |                     | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |
| 22a. I certify that (I) this hospital/attended the deceased from <b>10/15/80</b> to <b>11/13/80</b> that (I) (we) last saw the deceased alive on <b>11/13/80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated.                               |                     |  |  |  |   |
| 22b. SIGNATURE<br><b>RC Kruze</b>   |                     | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>11/13/80</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RC KRUZE</b>  |                     | 22e. ADDRESS<br><b>Mercy Hosp.</b>   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |                     | 23b. DATE<br><b>11/20/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Memorial Pk.</b>              |   |
| 23d. LOCATION<br>CITY OR TOWN<br><b>Baltimore</b>   |                     | COUNTY<br><b>Baltimore</b>   |  | STATE<br><b>MD</b>   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>WILLIAM C. MARCH FUNERAL HOME INC.</b>   |                     | ADDRESS<br><b>1101 E. North Ave.</b>   |  | 25. DATE REC'D. BY REGISTRAR<br><b>NOV 19 1980</b>                             |   |



DHMH-16 30M 2/80  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed and signed by the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be attached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 0 2 7 9 3 8  |  |
|---|--|--|--|--|--|
| 1 - FOR STATE REGISTRAR   |  |  |  | CERTIFICATE OF DEATH   |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  | 2a. DATE OF DEATH  |  |
| FIRST MIDDLE LAST<br>CHARLES R. CLAY  |  |  |  | MONTH DAY YEAR<br>11/26/80   |  |
| 3. SEX<br>Male  |  |  |  | 2b. HOUR<br>4:30a  |  |
| 4. RACE<br>Negro  |  |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 8 16   |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>64   |  |  |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD   |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>JOHNS HOPKINS HOSPITAL  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>MD  |  |  |  | 13b. COUNTY  |  |
| 13c. CITY OR TOWN<br>Baltimore  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 13e. STREET ADDRESS<br>2309 N. Aisquith St.   |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles P. Clay   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Bertha Chase  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |  |  |  | 16b. SOCIAL SECURITY NO.<br>217-01-8997  |  |
| 17. INFORMANT<br>ADDRESS<br>Lenora J. Clay 2309 N. Aisquith St.   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory arrest</u><br><u>1509</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>aspiration pneumonia and sepsis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(c) <u>esophageal carcinoma</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 minute</u><br><u>6 hrs</u><br><u>5 months</u> |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d)   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/26</u> , 19 <u>80</u> , to <u>11/26</u> , 19 <u>80</u> , that (I) (we) lost<br>saw the deceased alive on <u>11/26</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |
| 22b. SIGNATURE<br><u>David B Pearse M.D.</u>  |  |  |  | 22c. DATE SIGNED<br><u>11/26/80</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DAVID B PEARSE M.D.  |  |  |  | 22e. ADDRESS<br>JOHNS HOPKINS HOSPITAL   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |  |  | 23b. DATE<br>12/2/80   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Crownsville VA Cem.   |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Crownsville MD   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 28 1980   |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>Henry A. Brady</u>   |  |  |  |  |  |

1945 JAN 10 10 10 AM '45

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |   |  | REG. NO.  |  |                              |  |
|--|--|---|--|---|--|---|--|---|--|---|--|------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>COVINGTON W. COCKEY</b>   |  |   |  |   |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 2 80</b> |  | 2b. HOUR<br><b>7:45 P.M.</b> |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Feb. 26, 1896</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN.                        |  |                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.   |  |   |  |   |  |                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Accounting</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Railroad</b>  |  |   |  |                              |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>Calvertand 31st Sts.</b>  |  |   |  |                              |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles Cockey</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Eva Jonston</b>   |  |   |  |   |  |   |  |                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>705-10-8701</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>414 E. Lake Ave.,<br/>Douglas Swartz Baltimore, Maryland 21212</b>   |  |   |  |   |  |   |  |                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CHF</b><br><b>4273</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Actual Fib &amp; Rapid Vent Response</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):<br><b>Sepsis - treated</b> |  |   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH       |  |                              |  |
| 19a. DATE OF OPERATION<br>—  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>—   |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |   |  |                              |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |   |  |                              |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>Oct 19</b> , 19 <b>80</b> , to <b>Nov 3</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>Nov 2</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |   |  |   |  |                              |  |
| 22b. SIGNATURE<br><b>Ann E Duerr, M.D.</b>   |  |   |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11/2/80</b>  |  |   |  |                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Ann E Duerr, MD</b>  |  |   |  | 22e. ADDRESS<br><b>201 E. University Parkway, Balto</b>   |  |   |  |   |  |   |  |                              |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Nov. 5, 1980</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Evergreen Memorial Gardens</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Finksburg, Carroll, Md.</b>  |  |   |  |   |  |                              |  |
| 24. FUNERAL DIRECTOR<br><b>H. Ehlhardt</b>   |  |   |  | 25. DATE RECEIVED BY CLERK<br><b>NOV 7 1980</b>   |  | 25. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |   |  |   |  |                              |  |

COVINGTON N. COCKEY

Feb. 28, 1898

BALTIMORE CITY

UNION MEMORIAL HOSPITAL

BALTIMORE

Baltimore

Baltimore

Ms.

Baltimore

Cockey

Ms.

705-1-2001  
Baltimore, Maryland  
1898

Ms. 705-1-2001  
Baltimore, Maryland  
1898



12

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

2 7 9 4 0

REG. NO.

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Janet Cohen</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 19, 1980</b>                      |   | 2b. HOUR<br>M  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 8, 1903</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.                                 | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Poland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                 |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore City</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>4000 Echodale Ave.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>  |  |   | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Peter Gorecki</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Wanda Chotkowski</b>             |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>216-07-4347</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Casimir J. Gorecki 2632 Norland Ave. Balt. Md.</b> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>C.V.A.</b><br><b>4360</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Hypertension</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>         | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-28-76</b> , 19 <b>1980</b> , to <b>11-1</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>11-1</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we (did) (did not) view the body after death.       |  |   |  |   |  |
| 22b. SIGNATURE<br>  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>11-20-80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>S Russo MD</b>  |  | 22e. ADDRESS<br><b>5722 Norfolk Rd</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Nov. 24, 1980</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Stanislaus</b>                       |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balt. Co. Maryland</b>   |  | 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J. Ruck, Inc Balt., Md.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 24 1980</b>                               |  |
| 25b. REGISTRAR'S SIGNATURE<br>  |  |   |  |   |  |



November 12, 1953

Cohen

and

NY

July 6, 1953

NY

NY

Baltimore City

NY

NY

NY

House

1000 E. Baltimore Ave.

Baltimore City

1000 E. Baltimore Ave.

NY

Baltimore

NY

Chesapeake

NY

Baltimore

NY

1000 E. Baltimore Ave. Baltimore, Md.

NY

NY

NY

NY

NY

NY

NY

NY

NY



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 7 9 4 1

REG. NO.

|  |  |   |  |  |  |   |  |  |
|--|--|---|--|--|--|---|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Sarah Cohen</i>  |  |   | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><i>11/13/80</i>          |  | 2b HOUR<br><i>5:20 P.M.</i>  |   |  |  |
| 3 SEX<br><i>Female</i>   |  | 4 RACE<br><i>White</i>  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><i>4 24 97</i>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS HOURS MIN.<br><i>83</i>  |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>MARYLAND</i>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.  |  |  |
| 10 CITY OR TOWN OF DEATH<br><i>city</i>  |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>The Good Samaritan Hosp.</i> |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>HOUSEWIFE</i>  |  | 12b KIND OF BUSINESS OR INDUSTRY<br><i>AT HOME</i>  |  |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br><i>Maryland</i>  |  |   | 13b COUNTY<br><i>Baltimore City</i>                            |  | 13c CITY OR TOWN<br><i>Baltimore City</i>                          |   | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 13e STREET ADDRESS<br><i>4422 Hamilton Ave</i>   |  |   | 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Samuel Sartoph</i> |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Ida UNKNOWN</i> |   | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>NO</i>               |  |
| 16b SOCIAL SECURITY NO.<br><i>212-01-6003</i>  |  |   | 17 INFORMANT<br><i>MRS. SELMA CURTIN</i>                       |  | 17 ADDRESS<br><i>4422 HAMILTON AVE. BALTO., MD 21206</i>           |   | 18 CAUSE OF DEATH  |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <i>Cardiopulmonary Arrest</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Advanced metastatic Ca. of Lung.</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____   |  |   |  |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____  |  |   |  |  |  |   |  |  |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |
| 22a I certify that (1) (this hospital) attended the deceased from <i>Oct. 27</i> , 19 <i>80</i> , to <i>Nov. 13</i> , 19 <i>80</i> , that (1) <input checked="" type="checkbox"/> met last saw the deceased alive on <i>Nov. 13</i> , 19 <i>80</i> , and that in <input checked="" type="checkbox"/> my <input type="checkbox"/> their opinion death occurred on the date and hour and from the causes stated above. (1) <input checked="" type="checkbox"/> we did not view the body after death. |  |   |  |  |  |   |  |  |
| 22b SIGNATURE<br><i>Jungsin Lee M.D.</i>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |  | 22c DATE SIGNED<br><i>Nov. 13, 1980</i>   |  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>JUNG-SIN LEE</i>  |  |   |  | 22e ADDRESS<br><i>The Good Samaritan Hosp.</i>   |  |   |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>BURIAL</i>  |  | 23b DATE<br><i>11/14/80</i>   |  | 23c NAME OF CEMETERY OR CREMATORY<br><i>ANSHE EMUNAH</i>   |  | 23d LOCATION<br>CITY OR TOWN COUNTY<br><i>BALTIMORE MARYLAND</i>  |  |  |
| 24 FUNERAL DIRECTOR<br><i>SOL LEVINSON &amp; BROS., INC.</i>   |  |   |  | 25a DATE REC'D. BY REGISTRAR<br><i>NOV 18 1980</i>   |  | 25b REGISTRAR'S SIGNATURE<br><i>Rafael A. Cruz</i>  |  |  |
| 24 ADDRESS<br><i>6010 REISTERSTOWN RD. BALTO., MD 21215</i>  |  |   |  |  |  |   |  |  |

BP.

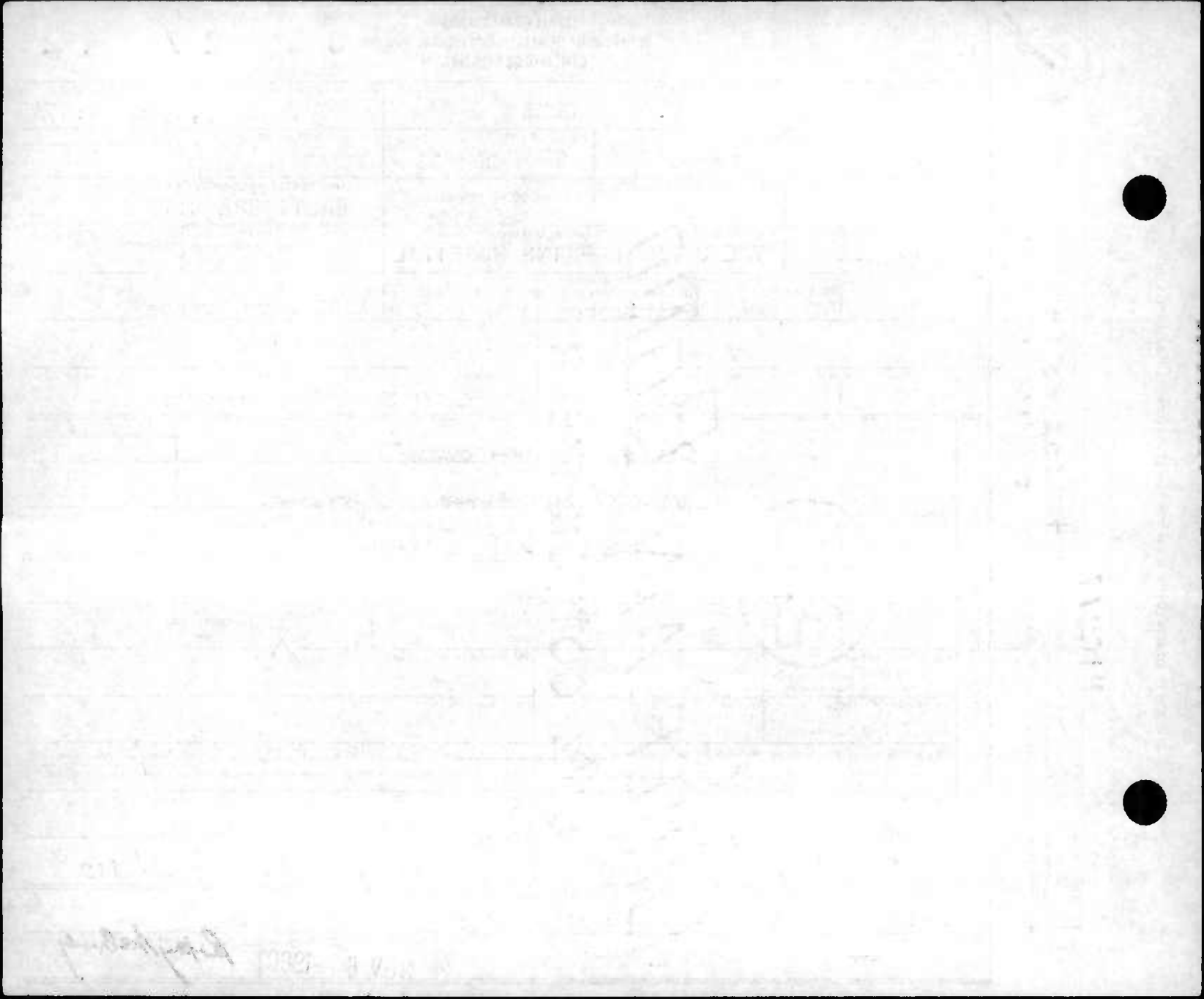
NOV 18 1930

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial transit permit. Then please remove card to papers. Page 4 may be retained by the funeral director.

IMPORTANT: If item 21 is marked of item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |   |  |  |  |  |                  | 8 0 2 7 9 4 2   |  |                   |
|--|--|---|--|---|--|--|--|--|------------------|---|--|-------------------|
| 1. FOR STATE REGISTRAR   |  |   |  |   |  |  |  |  |                  | REG. NO.  |  |                   |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>LOUISE V. COLE   |  |   |  |   |  |  |  |  |                  | 2a. DATE OF DEATH MONTH DAY YEAR<br>NOVEMBER 5, 1980  |  | 2b. HOUR<br>4:17A |
| 3. SEX<br>Female   |  | 4. RACE<br>Negro  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>5 22 13  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br>67                                     |  | IF UNDER 1 YEAR MONTHS DAYS  |                  | IF UNDER 24 HRS. HOURS MIN.   |  |                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                     |  |  |                  |   |  |                   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               |  | 12b. KIND OF BUSINESS OR INDUSTRY  |                  |   |  |                   |
| 13a. STATE<br>MD   |  |   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                  | 13e. STREET ADDRESS<br>1905 Park Avenue   |  |                   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>James Washington  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Mary Parker   |  |  |  |  |                  |   |  |                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  |   |  | 16b. SOCIAL SECURITY NO.<br>227-14-8252   |  | 17. INFORMANT ADDRESS<br>Sarah Little 24 N. Mount St.                          |  |  |                  |   |  |                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u><br>2866<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>prolonged hypertension / hypoxemia</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>bleeding ? DIC ? sepsis.</u>                                  |  |   |  |   |  |  |  |  |                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>Chronic Renal failure</u>   |  |   |  |   |  |  |  |  |                  |   |  |                   |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY HOUR MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) |  |  |                  |   |  |                   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK OR NOT WHILE <input type="checkbox"/> AT WORK  |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |  |                  |   |  |                   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/2</u> 19 <u>80</u> , to <u>11/5</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>11/5</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |  |                  |   |  |                   |
| 22b. SIGNATURE<br><u>J. Mannisi</u> MD   |  |   |  |   |  | DEGREE<br>MD   |  |  | 22c. DATE SIGNED |   |  |                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>J. Mannisi MD   |  |   |  |   |  | 22e. ADDRESS<br>601 N. Broadway Balt MD  |  |  |                  |   |  |                   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |   |  | 23b. DATE<br>11/8/80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Family Cemetery                          |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Stafford Co. Va.                                  |                  |   |  |                   |
| 24. FUNERAL DIRECTOR NAME<br>Wm C March F/H  |  |   |  |   |  | 1101 E. North Ave.   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 6 1980  |                  | 25b. REGISTERED SIGNATURE<br><u>Roy H. H. H.</u>  |  |                   |



BP

DHMH - 16 50M 1/76  
(VR A 15 (4))

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 7 9 4 3

REG. NO.

|   |  |   |   |   |                             |  |
|---|--|---|---|---|-----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Margaret C. Collier</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11- 2- 80</b> |   | 2b. HOUR<br><b>3:45 P M</b> |  |
| 3. SEX<br><b>female</b>   |  | 4. RACE<br><b>white</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 17, 1898</b>  |                             |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b>  |  | 7. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Wash. D.C.</b>  |  | 7b. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore</b> MD  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore</b> City MD  |                             |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(GIVE ADDRESS AND CITY)<br><b>John F. Hartman Home 21229</b>                               |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Secretary</b>  |                             |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   |  | 13b. CITY OR TOWN<br><b>Montgomery</b>  |   | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                             |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Richard B. Hayden</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Cora Brinkley</b>   |   | 16. STREET ADDRESS<br><b>2102 Cascade Rd.</b>   |                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>252 24 3824</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Rita B. Tozzolo #13</b>   |                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b><br><b>4029</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <b>HA SCVD.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>15 MIN</b><br><b>10 YRS</b> |  |   |   |   |                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |   |   |                             |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                             |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |   |   |                             |  |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |                             |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                             |  |
| 22a. I certify that (this hospital) attended the deceased from <b>12-17</b> , 19 <b>76</b> , to <b>Nov. 2</b> , 19 <b>80</b> , that (we) last saw the deceased alive on <b>Nov. 2</b> , 19 <b>80</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) view the body after death.  |  |   |   |   |                             |  |
| 22b. SIGNATURE<br><b>John F. Hartman</b>  |  | DEGREE<br><b>M.D.</b>   |   | 22c. DATE SIGNED<br><b>11-2-1980</b>  |                             |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOHN F. HARTMAN, M.D.</b>   |  | 22e. ADDRESS<br><b>1000 S. CATON AVE. BALTO MD 21229</b>  |   |   |                             |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Nov. 5, 1980</b>  |   | 23c. NAME OF CEMETERY<br><b>congressional</b>   |                             |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Wash. D.C.</b>   |  | 24. FUNERAL DIRECTOR<br>NAME<br><b>Taltavull Funeral Home</b><br><b>4748 Wisc. Ave. N.W. Wash. D.C. 20016</b>   |   |   |                             |  |
| 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 6 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Hartman</b>  |   |   |                             |  |

MEDICAL CERTIFICATION

47

90

35

150

2

2

9

1

3902



13 0081 11 100 31

100 31

100 31

100 31

100 31

100 31

100 31

100 31

100 31

100 31

100 31

100 31

100 31

100 31

100 31

100 31

100 31

100 31

100 31

100 31

100 31

100 31

100 31

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80

27944

REG. NO.

|   |  |   |        |   |                   |  |       |   |      |  |   |
|---|--|---|--------|---|-------------------|--|-------|---|------|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST   | MIDDLE | LAST  | 2a. DATE OF DEATH |  | MONTH | DAY   | YEAR | 2b. HOUR                                     |   |
| Ruby  |  |   |        | Collins   | 11                |  | 19    | 80  |      |  | M |
| 3. SEX  |  | 4. RACE   |        | 5. DATE OF BIRTH  |                   | 6. AGE (IN YEARS LAST BIRTHDAY)  |       | IF UNDER 1 YEAR   |      | IF UNDER 24 HRS                              |   |
| Female  |  | Black   |        | 10 18 08  |                   | 72   |       | MONTHS DAYS   |      | HOURS MIN.                                   |   |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                     |                   | 9. BALTIMORE CITY OR COUNTY OF DEATH                                   |       |   |      |  |   |
| Maryland  |  | USA   |        |   |                   | Baltimore City MD.   |       |   |      |  |   |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |        |   |                   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)       |       | 12b. KIND OF BUSINESS OR INDUSTRY   |      |  |   |
| Baltimore   |  | Union Memorial Hospital   |        |   |                   |  |       |   |      |  |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13b. COUNTY   |        | 13d. INSIDE CITY LIMITS?  |                   | 13e. STREET ADDRESS  |       |   |      |  |   |
| Maryland  |  | Baltimore   |        | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                   | 426 Winston Avenue   |       |   |      |  |   |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME  |        |   |                   |  |       |   |      |  |   |
| William   |  | Margaret  |        |   |                   |  |       |   |      |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |        | 17. INFORMANT   |                   | ADDRESS  |       |   |      |  |   |
| No  |  | 212-26-7723   |        | Anne Addison  |                   | 4703 Wakefield Road  |       |   |      |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Aortic occlusion</u><br>4441<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO OR AS A CONSEQUENCE OF<br>DUE TO OR AS A CONSEQUENCE OF |  |   |        |   |                   |  |       |   |      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c):<br><u>Aplastic Anemia.</u>   |  |   |        |   |                   |  |       |   |      |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |        |   |                   | 20a. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO |       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO |      |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                   |  |       |   |      |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |        | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                   |  |       |   |      |  |   |
| 22a. I certify that (this hospital) attended the deceased from <u>11/19</u> , 19 <u>80</u> , to <u>11/19</u> , 19 <u>80</u> , that (we) last saw the deceased alive on <u>11/19/80</u> , 19 <u>80</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (didn't) view the body after death.        |  |   |        |   |                   |  |       |   |      |  |   |
| 22b. SIGNATURE<br><u>Samir Shureih</u>  |  |   |        | DEGREE<br><u>MD</u><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                   |  |       | 22c. DATE SIGNED<br><u>11/19/80</u>   |      |  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Samir Shureih</u>   |  |   |        | 22e. ADDRESS<br><u>UMH.</u>   |                   |  |       |   |      |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE   |        | 23c. NAME OF CEMETERY OR CREMATORY  |                   | 23d. LOCATION<br>CITY OR TOWN COUNTY MD                                |       |   |      |  |   |
| Burial  |  | 11/24/80  |        | King Memorial Park  |                   | Baltimore  |       |   |      |  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>William C. March</u>   |  |   |        | ADDRESS<br><u>1101 E. North Ave</u>   |                   | 25a. DATE REC'D. BY REGISTRAR<br><u>NOV 21 1980</u>                    |       | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |      |  |   |





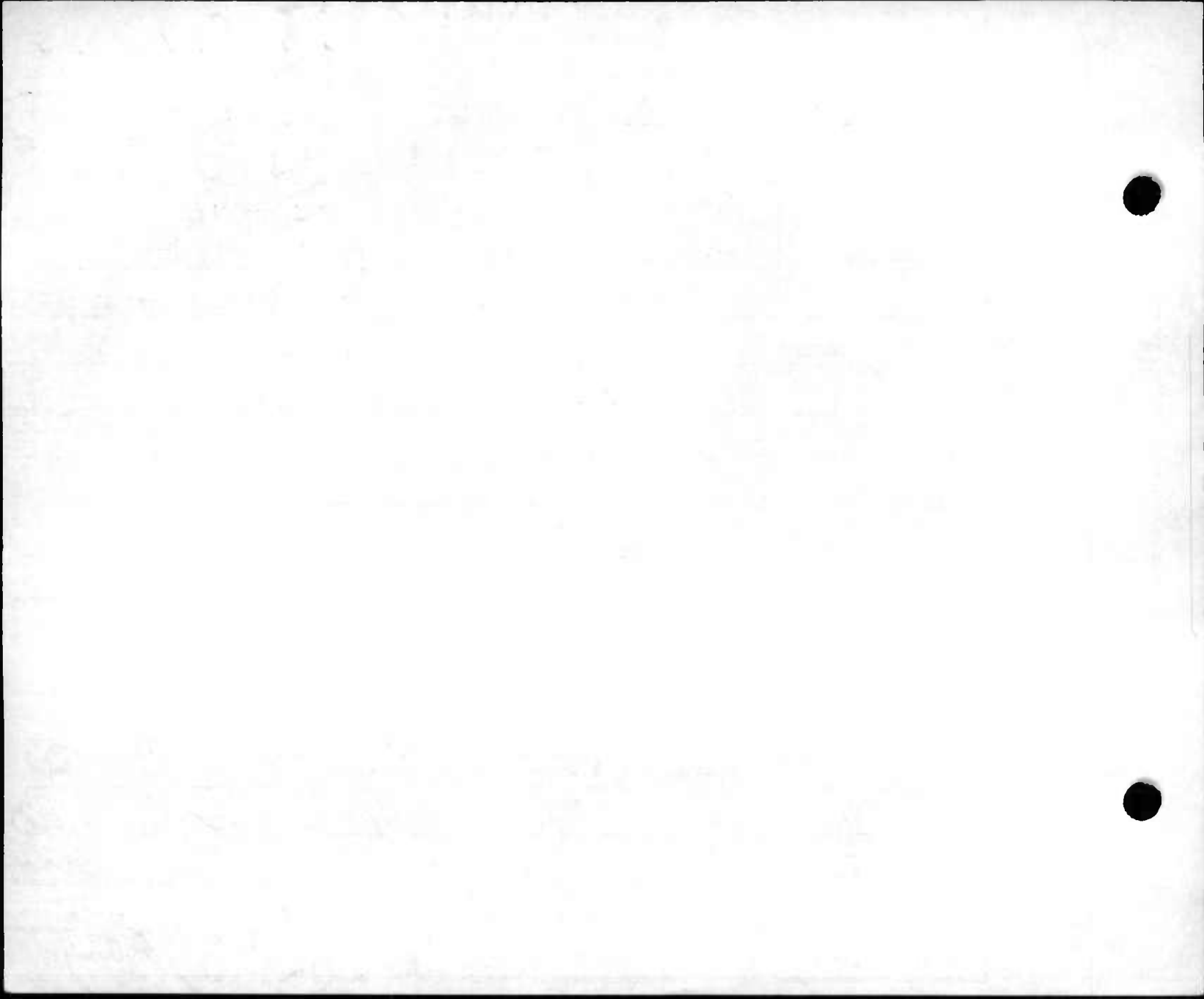
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 0 2 7 9 4 5<br>REG. NO.  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CYNTHIA EFFIE COMBS  |  |   |  | 11 06 80 330 AM  |  |  |  |
| 3. SEX Female   |  | 4. RACE White   |  | 5. DATE OF BIRTH MONTH DAY YEAR 5/21/ 1892   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 88   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky  |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.  |  |
| 10. CITY OR TOWN OF DEATH Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospitals |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE Maryland   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN Baltimore  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                           |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN  |  | 13e. STREET ADDRESS 1269 Armistead Way 21205   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No  |  | 16b. SOCIAL SECURITY NO. 202.22.7654A   |  | 17. INFORMANT ADDRESS William G. Combs, Jr. 7308 Arthur Dr., Falls Church Va 22046   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory Arrest   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |
| 4960 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) COPD, pneumonia  |  |   |  | Years.   |  |  |  |
| (c) DUE TO OR AS A CONSEQUENCE OF DUE TO OR AS A CONSEQUENCE OF   |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: R heel ulcer, Senile Dementia, ASHD, S/P L hemiplegia  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES/WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from June 19 1980 to Nov 6 1980 that (I) (we) lost saw the deceased alive on Nov 6 1980 and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death. |  |   |  |  |  |  |  |
| 22b. SIGNATURE Vikas Sami   |  |   |  | DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>   |  | 22c. DATE SIGNED Nov 6, 1980   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) VIKAS SAINI   |  |   |  | 22e. ADDRESS 4940 Eastern Ave; Balt. 21229   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation   |  | 23b. DATE 11/8/1980   |  | 23c. NAME OF CEMETERY OR CREMATORY Green Mount Crematory   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland   |  |
| 24. FUNERAL DIRECTOR NAME Walter Brooks Bradley, Inc., Dundalk Md 21222   |  |   |  | 25a. DATE REC'D. BY REGISTRAR NOV 12 1980  |  | 25b. REGISTRAR'S SIGNATURE [Signature]   |  |



M

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

80 27946

|   |  |  |  |   |   |  |  |  |
|---|--|--|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>THOMAS C. CONDON</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 23 80</b> |   |   | 2b. HOUR<br><b>7:30 PM</b>   |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>09 20 17</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b> YRS                             |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>IOWA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD             |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. AGNES HOSPITAL</b> |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>PRODUCTION MANA-</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>NEWSPAPER</b>  |  |
| 13a. STATE<br><b>MARYLAND</b>   |  |  |  | 13b. COUNTY<br><b>---</b>   |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>EDWARD CONDON</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>CATHERINE WALSH</b>   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>WW II</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>480-05-6105</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>JOHN T. CONDON 4816 COLEHERNE ROAD, 21229</b>  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Vertebral Arteriosclerosis</u><br><b>4141</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Severe Emphysema</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____   |  |  |  |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |   |  |  |  |
| 22b. SIGNATURE<br><u>Victor Jaworsky</u>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   | 22c. DATE SIGNED<br><b>11/23/80</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Victor Jaworsky</b>   |  |  |  | 22e. ADDRESS<br><b>St. Agnes Hospital<br/>900 Caton Avenue, Baltimore, Maryland</b>   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>11-26-80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>NEW CATHEDRAL</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE CITY MARYLAND</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>HUBBARD FUNERAL HOME, INC.</b>   |  |  |  | 24b. ADDRESS<br><b>4107 WILKENS AVE.</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 26 1980</b>                          |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION



RECEIVED  
1944 OCT 10 10 10 AM  
U.S. DEPARTMENT OF THE ARMY  
WASHINGTON, D.C.

*[Faint, mostly illegible text and markings covering the majority of the page, possibly representing a memorandum or report.]*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 27947

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |   |   |   |  |   |
|--|---|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>THEODORE DOUGLAS CONSTANTINE  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11-8-80  |  | 2b. HOUR<br>1 P.M.  |
| 3. SEX<br>M  | 4. RACE<br>W  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 22 92   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>85 YRS                  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD. |   |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>EDEWOOD NURSING HOME |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Stone Mason         | 12b. KIND OF BUSINESS OR INDUSTRY<br>Construction          |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>md |   |   | 13b. COUNTY<br>Balto  | 13c. CITY OR TOWN<br>Owings Mills                          | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Constantine  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary ?                                 |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>yes WWI      |   | 16b. SOCIAL SECURITY NO.<br>218-01-1346   | 17. INFORMANT<br>William L. Ford<br>ADDRESS<br>107 Gwynnbrook Ave.<br>Owings Mills, Md. |  |   |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a) Cerebral Arteriosclerosis  
4292  
DUE TO, OR AS A CONSEQUENCE OF  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  
(b) A. S. C. V. D.  
DUE TO, OR AS A CONSEQUENCE OF  
(c) GENERAL Arteriosclerosis

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

|  |                            |  |  |   |  |
|--|----------------------------|--|--|---|--|
| 19a. DATE OF OPERATION   |                            | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |                            | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |                            | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/19/79 to 11/8/80, that (I) (we) last saw the deceased alive on 11-8-80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |                            |  |  |   |  |
| 22b. SIGNATURE<br>Anthony F. PAROZZA MD.   |                            | DEGREE   |  | 22c. DATE SIGNED<br>11/9/80.  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |                            | 22e. ADDRESS<br>6000 Bellona Ave Balto Md                              |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   | 23b. DATE<br>Nov. 10, 1980 | 23c. NAME OF CEMETERY OR CREMATORY<br>All Saints Cemetery              |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Reisterstown, Balto. Co., Md. |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>H. E. Ellhardt   |                            | ADDRESS<br>Owings Mills, Md.   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 13 1980                                | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |

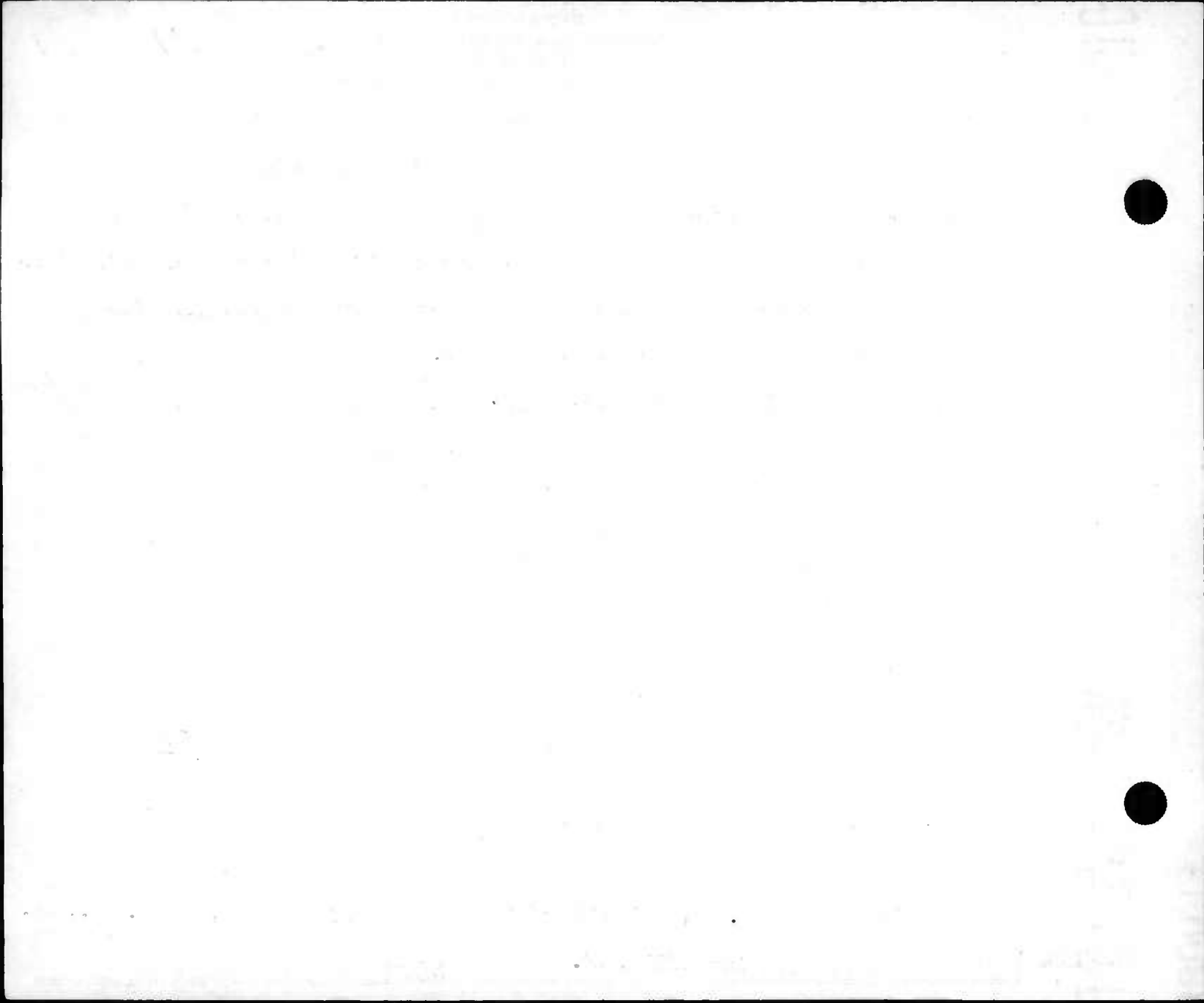
TO HOSPITAL SURGEON ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP  
DHMH-16 20M  
(VRA 15, 4) 7/78

4042

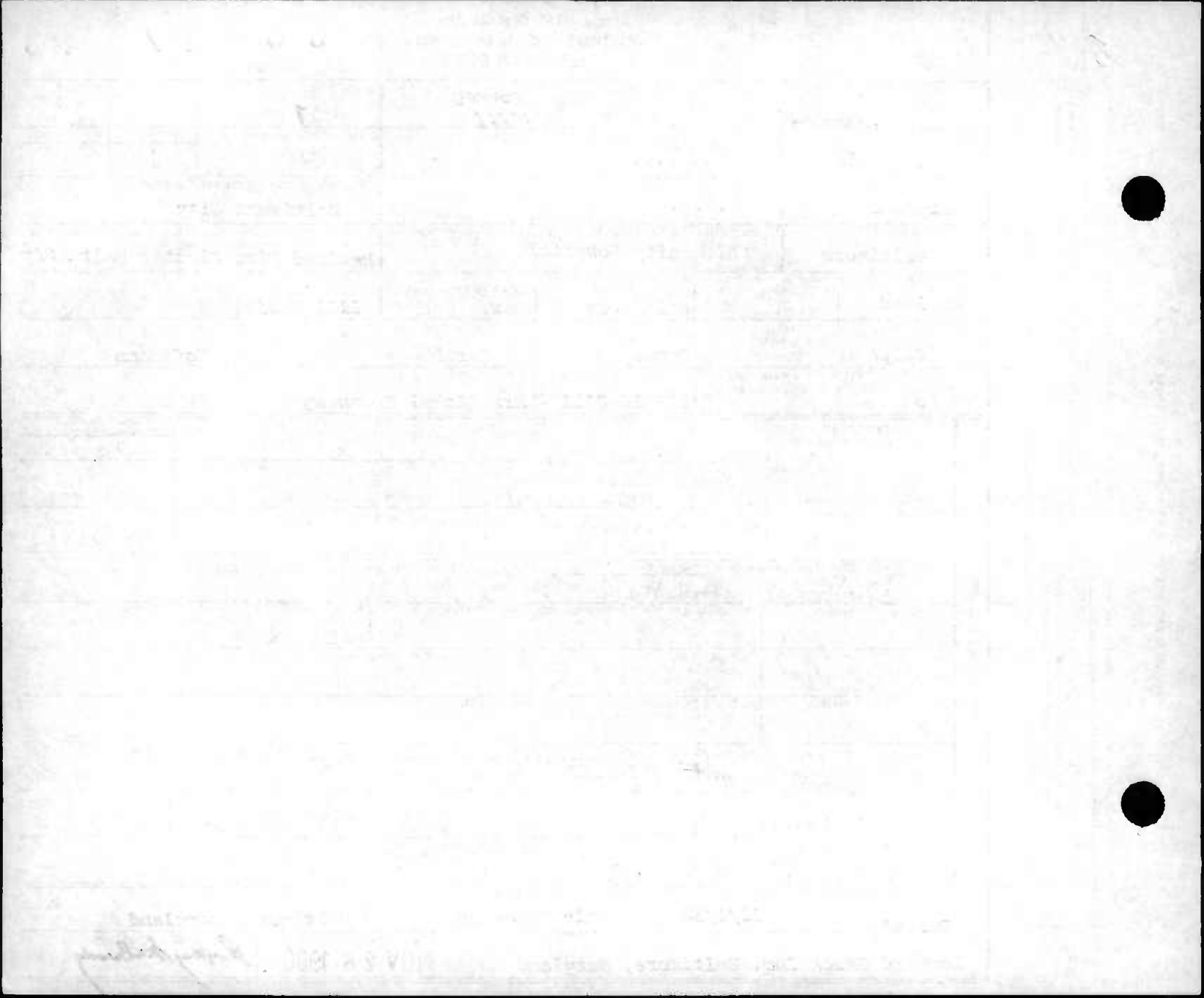


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |  |  |   |  | REG. NO. 80 27948   |  |
|--|--|---|--|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  |  |  |  |  |   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <u>Conway Edward N Gorky</u>  |  |   |  |  |  | 20. DATE OF DEATH MONTH DAY YEAR <u>11/27/80</u>   |  | 2b. HOUR <u>2:27 P.M.</u>   |  |   |  |
| 3. SEX <u>M Male</u>   |  | 4. RACE <u>White</u>  |  | 5. DATE OF BIRTH MONTH DAY YEAR <u>9 19 06</u>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <u>74</u> YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>  |  | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD.                               |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH <u>Baltimore</u>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>University Hospital</u> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Retired Fire Fighter</u>    |  | 12b. KIND OF BUSINESS OR INDUSTRY <u>Balt. City</u>   |  |   |  |
| 13a. STATE <u>Maryland</u>   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN <u>Baltimore</u>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <u>1128 Hewitt Way</u>  |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <u>Ralph Conway</u>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Sarah Hoffmann</u>   |  |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>  |  | 16b. SOCIAL SECURITY NO. <u>219-10-2111</u>   |  | 17. INFORMANT ADDRESS <u>Mrs Rachel E Conway Same</u>  |  |  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><u>4100</u> IMMEDIATE CAUSE (a) <u>Respiratory + Cardiac Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>CH Congestive Heart Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>VSD / MI 2° to MI</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Diabetes Mellitus</u> |  |   |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>20 min</u><br><u>10 Days</u><br><u>10 Days</u>   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M. 19</u>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/18</u> 19 <u>80</u> , to <u>11/27</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>11/27</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |  |  |   |  | 22b. SIGNATURE <u>J. Posner, MD</u> DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 22c. DATE SIGNED <u>11/27/80</u>   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>J. POSNER, MD</u> 22e. ADDRESS <u>Univ. Hospital</u>                                     |  |  |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>  |  | 23b. DATE <u>12/1/80</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore, Maryland</u>                           |  |   |  |   |  |
| 24. FUNERAL DIRECTOR NAME <u>Leonard JRuck Inc. Baltimore, Maryland</u> ADDRESS  |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR <u>NOV 28 1980</u>   |  | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>   |  |   |  |





10 20 56

10 20 56

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. The law requires that the death certificate be executed within 24 hours of the death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 30M 2/80  
(VRA 15, 4)1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 7 9 4 9

REG. NO.

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><i>Elizabeth (BETTY) M. COOK</i>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>NOVEMBER 11, 1980</i>                            |  | 2b. HOUR<br><i>06:20 AM</i>                          |
| 3. SEX<br><i>Female</i>   | 4. RACE<br><i>White</i>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>October 23, 1914</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><i>66</i>   | IF UNDER 1 YEAR<br>IF UNDER 24 HRS.<br>HOURS MIN.    |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>New York</i>  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>BALTIMORE CITY</i> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>THE JOHNS HOPKINS HOSPITAL</i> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Business Office</i> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Hospital</i> |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE COUNTY CITY OR TOWN<br><i>Maryland Baltimore</i>  | 13b. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 13c. STREET ADDRESS<br><i>7321 SW 1st. Street</i>   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>John Christopher Monck</i>   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Sadie Mc Inerney</i>   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>NO</i>   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>216-07-7423</i>  | 17. INFORMANT<br>ADDRESS<br><i>Mr. George L. Cook, Sr. 7321 SW 1st. Street</i>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>RENAL FAILURE</i><br>4409<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>OCCLUDED RENAL ARTERIES</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>ARTERIOSCLEROTIC VASCULAR DISEASE</i> |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH         |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><i>GANGRENE @ FOOT, RESPIRATORY FAILURE</i>  |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><i>10/27 10/30</i>  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>ARTERIOSCLEROTIC AORTILIAC DISEASE</i>  |   | 20a. AUTOPSY?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <i>10-30</i> , 19 <i>80</i> , to <i>11-11</i> , 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>11-11-80</i> , 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |  |
| 22b. SIGNATURE<br><i>James A. Magovern MD</i>   |  | DEGREE<br><i>MD</i>   |  | 22c. DATE SIGNED<br><i>11-11-80</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>JAMES A. MAGOVERN</i>   |  | 22e. ADDRESS<br><i>JOHNS HOPKINS HOSP</i>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Cremation</i>   | 23b. DATE<br><i>11/15/80</i>   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Security Process, Inc.</i>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>atonsville Balto, Md.</i>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Mc Cully Funeral Home of Brooklyn</i>  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>NOV 12 1980</i>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Patricia McInerney</i>  |  |
| 237 E. Patapsco Avenue<br><i>Baltimore, Md. 21225</i>   |  |   |  |  |  |

1000

1000



APR 10 1960

NOV 13 1960

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21a is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Released on approval by Medical Examiner

MEDICAL CERTIFICATION

| Items 21a-22a G555 5/21/81 dad  |  |  |  | STATE OF MARYLAND  |  | 8027950  |  |
|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  | CERTIFICATE OF DEATH   |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  | 2a. DATE OF DEATH  |  | 2b. HOUR   |  |
| FIRST MIDDLE LAST<br>ARCHIE C. COOPER   |  |  |  | MONTH DAY YEAR<br>NOV 26 1980  |  | 6:17 AM  |  |
| 3 SEX<br>MALE   |  | 4 RACE<br>White  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>Dec. 31, 1888   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>91 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Rhode Island   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO. CITY MD  |  |
| 10 CITY OR TOWN OF DEATH<br>BALTO.  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BALTO. CITY Hosp. |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Salesman   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Paint Co.   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE COUNTY<br>Pennsylvania   |  |  |  | 13c. CITY OR TOWN<br>Hummelstown   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>James A. Cooper   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Agnes Stewart   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |  |  |  | 16b. SOCIAL SECURITY NO.<br>035-09-4711A   |  | 17 INFORMANT ADDRESS<br>Douglas S. Carr Funeral Home 24 Hill Street  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) GENERALIZED SEIZURE<br>8903<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) 23% TBSSA BURNS<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>20 MIN<br>3 DAYS |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br>CARDIAC DYSRHYTHMIAS  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>3:15pm 11/23/80   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br>subject in house fire  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>home   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>20 E. Main St., Hummelstown, Penna.   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from NOV. 23, 1980 to NOV. 26, 1980, that (I) (we) last saw the deceased alive on NOV. 26, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.           |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>Sally J. Trued  |  |  |  |  |  | 22c. DATE SIGNED<br>11/26/80   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>SALLY TRUED M.D.   |  |  |  |  |  | 22e. ADDRESS<br>BALTIMORE CITY HOSPITAL  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>12-1-1980   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Pine Grove   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Whitinsville Massachusetts   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Ruck Towson Funeral Home, Inc.  |  |  |  | ADDRESS<br>1050 York Road<br>Towson, Maryland  |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 1 1980  |  |

012

1

U

8

0

0

0

0

0

0

0

0

0

0

0

0

0

0

0

0

0

0

City

State

1904

City

State

1904

City

State

1904

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |   | 80 27951   |   |
|--|--|---|---|--|---|
| FOR<br>STATE<br>REGISTRAR  |  |   |   | REG. NO.   |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>JOHN CROSSAN COOPER Jr</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 19, 1980</b>                     |  | 2b. HOUR<br><b>9:50 A M</b>                                       |
| 1. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct. 16, 1901</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS.                                    | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                    |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>915 W. Lake Avenue</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Attorney</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Law</b>                   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  |   | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Baltimore</b>  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John C. Cooper</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Louisa Jenkins</b>              |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>217 03 8739</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>John C. Cooper, III Balto., Md.</b>                   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest Prob 2nd MI</b><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Atherosclerotic Cardiovascular disease</b><br>5yr +<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>10 MIN.</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____  |  |   |   |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |   |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>March 7</b> , 19 <b>59</b> , to <b>11/19</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>11/18</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. |  |   |   |  |   |
| 22b. SIGNATURE<br><b>John A. Nesbitt, III M.D.</b>   |  |   |   | 22c. DATE SIGNED<br><b>11/19/80</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. John A. Nesbitt, III, M.D.</b>   |  |   |   | 22e. ADDRESS<br><b>201 E. University Parkway, Balto., Md.</b>                        |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11/21/80</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral</b>                           |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto., Md.</b>   |  |   |   |  |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Henry W. Jenkins &amp; Sons Co. 4905 York Road Balto., Md. 21212</b>  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 20 1980</b>                                  |   |
|  |  |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony Helms</b>                                   |   |



John C. Cooper, III  
 217 W. Lake Avenue  
 Baltimore, Md.  
 John C. Cooper, III  
 217 W. Lake Avenue  
 Baltimore, Md.  
 John C. Cooper, III  
 217 W. Lake Avenue  
 Baltimore, Md.

*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page.]*

Dr. John A. Nesbitt, III, M.D.  
 1121 E. University Parkway, Baltimore, Md.  
 Dr. John A. Nesbitt, III, M.D.  
 1121 E. University Parkway, Baltimore, Md.

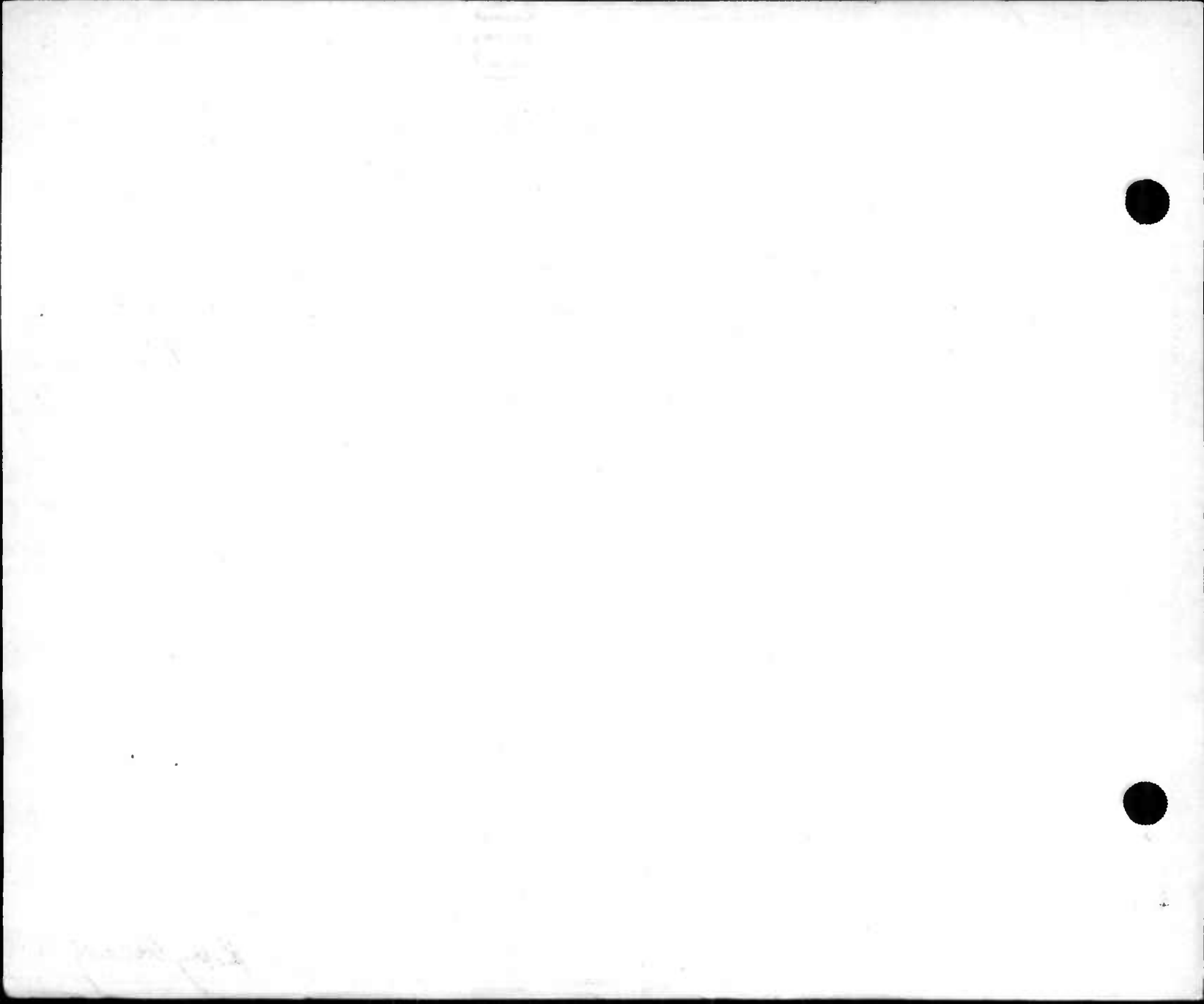
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 80 27952   |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  | REG. NO.   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <i>Cooper</i> <sup>LAST</sup> <i>Lottie J.</i> <sup>MIDDLE</sup>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR <i>11-5-80</i>  |  | 2b. HOUR <i>208</i> <sup>A M</sup>  |  |
| 3. SEX <i>Female</i>  |  | 4. RACE <i>B</i>  |  | 5. DATE OF BIRTH MONTH DAY YEAR <i>2 10 22</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <i>58</i> YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>   |  | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.  |  |
| 10. CITY OR TOWN OF DEATH <i>Baltimore</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Bon Secours</i> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Unemployed</i>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  | 13a. STREET ADDRESS <i>610 Wildwood Parkway</i>  |  |   |  |
| 13a. STATE <i>Baltimore</i>   |  | 13b. COUNTY <i>City</i>   |  | 13c. CITY OR TOWN <i>Maryland</i>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>                                       |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Drumwright Rosa</i>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>White Elbie</i>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>   |  | 16b. SOCIAL SECURITY NO. <i>215-16-9984</i>   |  | 17. INFORMANT <i>Robert B Cooper</i>   |  | ADDRESS <i>610 Wildwood Parkway</i>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |   |  |  |  |   |  |
| PART I. DEATH WAS CAUSED BY:  |  |   |  |  |  |   |  |
| IMMEDIATE CAUSE (a) <i>Tampon CA with infection</i>   |  |   |  |  |  |   |  |
| 1991  |  |   |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>Metastasis</i>  |  |   |  |  |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last   |  |   |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <i>Renal Failure</i>   |  |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>11/5</i> to <i>11/5</i> , 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>11/5</i> , 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |
| 22b. SIGNATURE <i>Rolanda A. Sabunday</i>   |  |   |  | DEGREE   |  | 22c. DATE SIGNED <i>11/5/80</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Rolanda A. Sabunday</i>  |  |   |  | 22e. ADDRESS <i>Bon Secours Hosp</i>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>   |  | 23b. DATE <i>11/10/80</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Auburn Cem.</i>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore, Md.</i>   |  |
| 24. FUNERAL DIRECTOR NAME <i>Wm C March F/H</i> ADDRESS <i>1101 E. North Ave.</i>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR <i>NOV 6 1980</i>  |  | 25b. REGISTRAR'S SIGNATURE <i>Rolanda Sabunday</i>  |  |





2 7 9 5 3

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |  |   |  |   |  |   |     |  |          |                                   |  |
|---|--|---|--|---|--|---|--|---|--|---|-----|--|----------|-----------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST   |  | MIDDLE  |  | LAST  |  | 2a. DATE OF DEATH   |  | MONTH                                       | DAY | YR.  | 2b. HOUR |                                   |  |
| STEVE   |  |   |  |   |  | CORLEY  |  | NOVEMBER 24, 1980   |  |   |     |  | 11:44    |                                   |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | 7. IF UNDER 1 YEAR  |  | 8. IF UNDER 24 HRS.                         |     |  |          |                                   |  |
| Male  |  | Negro   |  | 12 <sup>MONTH</sup> 24 <sup>DAY</sup> 10 <sup>YEAR</sup>  |  | 69  |  | MONTHS  |  | DAYS  |     | HOURS  |          | MIN.                              |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |  |   |  |   |     |  |          |                                   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |  |   |  |   |  |   |  |   |     | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |          | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| 13a. STATE<br>MD  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>2851 Woodbrook Ave.  |  |   |     |  |          |                                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Corley  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ida Carter   |  |   |  |   |  |   |     |  |          |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>264-07-7541  |  | 17. INFORMANT<br>ADDRESS<br>Gladys Knight 1517 N. Eden St.  |  |   |  |   |  |   |     |  |          |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST<br>5762<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) SEPSIS<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) BILIARY TRACT OBSTRUCTION                               |  |   |  |   |  |   |  |   |  |   |     | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |          |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br>METASTATIC PANCREATIC CANCER ATHEROSCLEROTIC HEART DISEASE  |  |   |  |   |  |   |  |   |  |   |     |  |          |                                   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |     |  |          |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |   |     |  |          |                                   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |   |     |  |          |                                   |  |
| 22a. I certify that (I) this hospital attended the deceased from Nov 16, 1980, to Nov 24, 1980, that (we) lost<br>saw the deceased arrive on Nov 24, 1980, and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>(above) (I) (we) (did not) view the body after death. |  |   |  |   |  |   |  |   |  |   |     |  |          |                                   |  |
| 22b. SIGNATURE<br>Steven T. Kariya MD   |  |   |  | DEGREE<br>MD  |  |   |  | 22c. DATE SIGNED<br>11-24-80  |  |   |     | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |          |                                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>STEVEN T. KARIYA   |  |   |  | 22e. ADDRESS<br>JOHNS HOPKINS HOSP., BALTIMORE MD   |  |   |  |   |  |   |     |  |          |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>11/29/80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>King Memorial pk  |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore MD  |  |   |     |  |          |                                   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H  |  |   |  | ADDRESS<br>1101 E. North Ave.   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 28 1980  |  | 25b. REGISTRAR'S SIGNATURE<br>Ricky Kebrady |     |  |          |                                   |  |

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, please detach this certificate from the body of the certificate and place it in the container for the body of the certificate. The certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

once. 70

33  
notifie

must be

3000  
exam

medica

|    |                       |
|----|-----------------------|
| 99 | MEDICAL CERTIFICATION |
|----|-----------------------|

9 FICAT

91 CER.

MEDICA

A

1

[illegible]

1

230

24

L

DHMH-16 30M 2/80  
(VRA 15, 4)

WALTON DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND 21201

COLEY STEVE

BP.

25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE



ST. LOUIS 8

1914

1914

10  
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

6 138 27 14

0833 BP  
DHMH-16 30M 2/80  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The low recorded death will be retained within 24 hours after death. Page 4 no.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |  |  | 8 0 2 7 9 5 4 |  |
|---|--|---|--|---|--|--|--|--|--|---------------|--|
| 1 - FOR<br>STATE<br>REGISTRAR   |  | REG. NO.  |  |   |  |  |  |  |  |               |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>WILLIAM CORNISH</b>  |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11/25/80</b>   |  | 2b. HOUR<br><b>5:34<sup>AM</sup></b>   |  |               |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10/30/12/</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Talors Is. Md</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. <b>BALTIMORE CITY OR COUNTY OF DEATH</b><br><b>BALTIMORE CITY</b> MD.   |  |  |  |               |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto. Md.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH PLACE, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |               |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE <b>Md</b> 13c. COUNTY <b>BALTO.</b> 13d. CITY OR TOWN <b>Balto.</b>  |  |   |  |   |  | 13e. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13f. STREET ADDRESS<br><b>2605 E. Oliver St.</b>   |  |               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Wm. H. Cornish</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Vera Cornish</b>  |  |  |  |  |  |               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>--</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Christine Stanley 2618 E. Oliver St.</b>   |  |  |  |  |  |               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b><br>0389<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>HYPOTENSION</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>SEPSIS</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 MIN</b><br><b>1 HR</b><br><b>24 HR</b> |  |   |  |   |  |  |  |  |  |               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>SQUAMOUS CELL CARCINOMA</b>   |  |   |  |   |  |  |  |  |  |               |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11-9</b> , 19 <b>80</b> , to <b>NOV 25</b> , 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>NOV 25</b> , 19 <b>80</b> , and that (I) (we) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.)  |  |   |  |   |  |  |  |  |  |               |  |
| 22b. SIGNATURE<br><b>Steven T. Kariya</b>   |  |   |  | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11-25-80</b>  |  |               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>STEVEN T. KARIYA</b>  |  |   |  | 22e. ADDRESS<br><b>JOHNS HOPKINS HOSP, BALTIMORE MD 21205</b>   |  |  |  |  |  |               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>  |  | 23b. DATE<br><b>11/29/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lane's United Ch. Cem</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Talors Island Md.</b>   |  |  |  |               |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>   |  |   |  | ADDRESS<br><b>1101 E. North Avenue</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 28 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Robert McBrady</i>  |  |               |  |



PROCESSED BY  
P. J. J. S. L. T. H.

Handwritten signature or initials.

1951 53 404

TO HOSPITAL OR ATTENDING PHYSICIAN: The low register for death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Please notify the funeral home of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 30M 2/80  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |  |  | REG. NO. |  |
|---|--|--|--|---|--|--|--|--|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Salvatore Cosentino</b>  |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 7, 1980</b>   |  | 2b. HOUR<br><b>12:05A</b>  |  |          |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept 1, 1910</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS.</b>   |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>  |  |  |  |          |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Union Organizer</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Teamsters</b>  |  |          |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>A.A.</b>   |  | 13c. CITY OR TOWN<br><b>Riviera Bch</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>178 Riviera Dr.</b>  |  |          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph Cosentino</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Johanna Suta</b>  |  |  |  |  |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>217 03 7297</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Antoinette Cosentino same as 13 e</b>  |  |  |  |  |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST</b>   |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>0</b>   |  |          |  |
| 4140<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>RECURRENT VENTRICULAR ARRHYTHMIAS.</b>   |  |  |  |   |  |  |  | <b>1 week</b>  |  |          |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ATHEROSCLEROTIC CORONARY ART. DISEASE</b>  |  |  |  |   |  |  |  | <b>3 yrs.</b>  |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |  |  |  |  |          |  |
| 19a. DATE OF OPERATION<br><b>—</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>—</b>   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |  |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/31</b> , 19 <b>81</b> , to <b>11/7</b> , 19 <b>80</b> , that (I) (we) lost<br>saw the deceased alive on <b>11/6</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |  |  |          |  |
| 22b. SIGNATURE<br><b>Ny. Hausknecht</b>   |  |  |  | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11/7/80</b>   |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HAUSKNECHT</b>  |  |  |  | 22e. ADDRESS<br><b>Johns Hopkins Hospital</b>   |  |  |  |  |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>11/10/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>   |  |  |  |          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>George J. Gonce</b>  |  |  |  | ADDRESS<br><b>4001 Ritchie Hgwy.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 10 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |          |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Department of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 42 hours after death.

1

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

27956

|  |  |  |   |   |  |   |   |   |   |  |
|--|--|--|---|---|--|---|---|---|---|--|
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br><b>ANDREW NMN COTTON</b>  |  |  | 2a. DATE OF DEATH<br>Month Day Year<br><b>11 15 80</b>  |   |  | 2b. HOUR<br><b>4:49 PM</b>  |   |   |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Black</b>                      |   | 5. DATE OF BIRTH<br><b>06-19-04</b>   |  | 6. AGE (In years last birthday)<br><b>76</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.          |   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>N.C.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b> |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>City</b> Md.   |   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Public Health Hospital</b> |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Retired</b>                       |   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Mer. Marine</b> |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>  |  |  | 13b. COUNTY<br><b>Pr. Geo.</b>  |   | 13c. CITY OR TOWN<br><b>Aquasco</b>                                |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br><b>22912 Banneker BLVD.</b>   |  |
| 14. FATHER'S NAME First Middle Last<br><b>Lsaac Cotton</b>   |  |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Flonnie Taylor</b>   |  |   |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>Yes</b><br>(If yes give war or dates of service) <b>Mer. Marines</b>  |  |  |   | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT Address<br><b>Roxie Cotton SAA</b>  |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary Insufficiency due</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>to Hemo thorax and Right</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Terminal Pneumonia</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |   |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |   |   |  |   |   |   |   |  |
| 19a. DATE OF OPERATION<br><b>Nov. 3, 1980</b>  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Cancer of Right Lung</b>                               |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN-CERTIFYING CAUSES OF DEATH?      |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                  |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |   |  |   |   |   |   |  |
| 22b. SIGNATURE<br><b>[Signature]</b> M.D. DEGREE   |  |  |   |   |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>11/16/80</b>                                       |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>FLORIANTE S. AUSTRIA</b>  |  |  |   |   |  | 22e. ADDRESS<br><b>3100 WYMAN PARK DRIVE BALTIMORE, MD 21211</b>  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>11/20/80</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lincoln Memorial Cem.</b> |   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Suitland P.G. Md.</b> |   |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Martell Adams Aquasco, Maryland 20608</b>   |  |  |   |   |  | 25a. REC'D BY REGISTRAR<br><b>NOV 24 1980</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                          |   |  |



Major

...

...

...

...

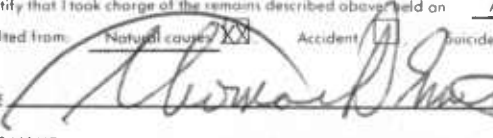

...

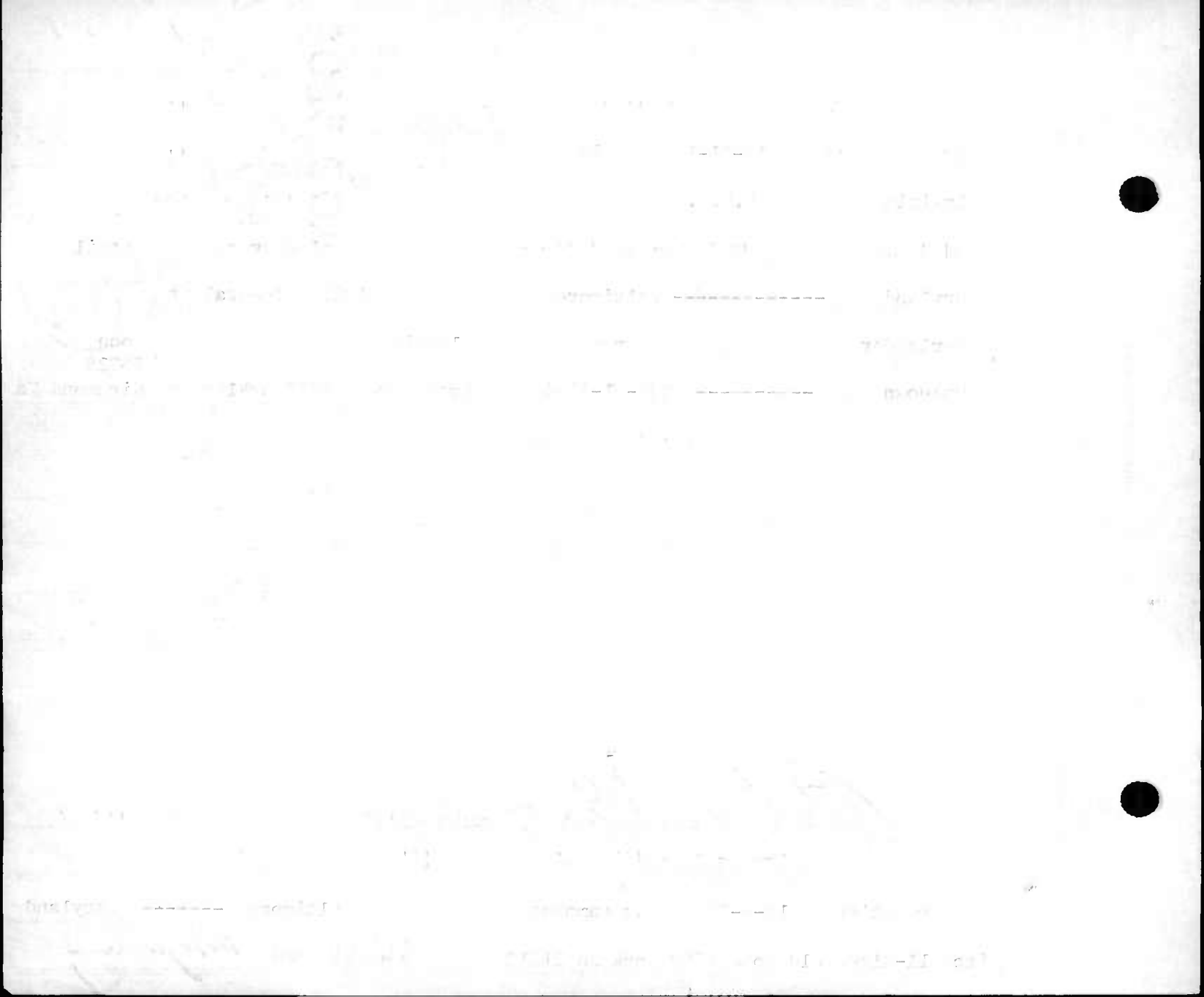
...



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                      |  |   |   |   |  |   |  | REG. NO. 0 27957   |  |                         |  |
|---|--|----------------------|--|---|---|---|--|---|--|--|--|-------------------------|--|
| 1. FOR STATE REGISTRAR  |  |                      |  |   |   |   |  |   |  |  |  |                         |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Zenda Carlisle Crews   |  |                      |  |   |   |   |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br>11 22 19 80                             |  | 2b. HOUR<br>M<br>2:44 P |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White     |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10-31-10  |   | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>70 YRS.   |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>11 24 19 80  |  | 2d. HOUR<br>P           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia   |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.  |  |                         |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1027 Cathedral Street |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Salesperson  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Retail  |  |                         |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |                      |  |   |   |   |  |   |  |  |  |                         |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>----- |  | 13c. CITY OR TOWN<br>Baltimore  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>1027 Cathedral St  |  |  |  |                         |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Verlander Crews   |  |                      |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Claudia Moon |   |  |   |  |  |  |                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>Unknown  |  |                      |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>-----<br>223-01-4744   |   | 17. INFORMANT<br>Partee Crews   |  |   |  | ADDRESS<br>8605 Ackley Ave Richmond Va   |  |                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>4254 Cardiomyopathy</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. |  |                      |  |   |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |                         |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.   |  |                      |  |   |   |   |  |   |  |  |  |                         |  |
| 19a. DATE OF OPERATION  |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |   |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |                         |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                      |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |  |   |  |  |  |                         |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |                         |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  |  |                      |  |   |   |   |  |   |  | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |                         |  |
| ACTUAL SIGNATURE<br>   |  |                      |  | TITLE (SPECIFY)<br>Deputy Chief   |   |   |  | MEDICAL EXAMINER  |  |  |  |                         |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Thomas D. Smith, M.D.   |  |                      |  | ADDRESS<br>111 Penn ST. Balto., MD.   |   |   |  | DATE SIGNED<br>11/25/80   |  |  |  |                         |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation   |  |                      |  | 23b. DATE<br>12-8-80  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Greenmount  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore ----- Maryland  |  |  |  |                         |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Mitchell-Wiedefeld Home 6500 York Rd 21212  |  |                      |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>DEC 10 1980  |  | 25b. REGISTRAR'S SIGNATURE<br>   |  |  |  |                         |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

2 7 9 5 8

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|   |  |  |   |   |                             |   |  |  |  |  |  |
|---|--|--|---|---|-----------------------------|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Edward F. Crigger Sr.</b>                      |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Nov. 14, 1980</b> |   | 2b. HOUR<br><b>10:25 PM</b> |   |  |  |  |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 29, 1912</b>  |                             | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>68</b>                                |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>0 0 0</b>  |  | 8. IF UNDER 24 HRS<br>HOURS MIN.<br><b>0 0</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                             | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>City</b>   |  |  |  | MD   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>House in Pines Belvedere</b> |   |   |                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Auto Mechanic</b>        |  | 12b. KIND OF BUSINESS OR INDUSTRY                  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                       |  |  |   |   |                             | 13a. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13b. STREET ADDRESS<br><b>2128 St. Paul Street</b> |  |  |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |                             |   |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Crigger</b>  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rose LLOYD</b>  |                             |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>no</b> |  |  |   | 16b. SOCIAL SECURITY NO.<br><b>223-10-9574</b>  |                             | 17. INFORMANT<br><b>Reverend, N.J.<br/>Rev. Michael S. Crigger 60 Cedar Street</b>              |  |  |  |  |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

4292

DUE TO, OR AS A CONSEQUENCE OF

(b)

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause lost

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

2 yrs

years

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10-28-80</b> to <b>Nov 15 1980</b> , that (I) (we) lost<br>saw the deceased alive on <b>Nov 15 1980</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>[Signature]</b> DEGREE   |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11/15/80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. R. A. Kochman</b>   |  |  |  | 22e. ADDRESS<br><b>10 Stonehenge Circle 21208</b>   |  |   |  |

|   |  |                                   |  |   |  |  |  |
|---|--|-----------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                           |  | 23b. DATE<br><b>Nov. 18, 1980</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Leonard J. Ruck Inc. Baltimore, Maryland</b> |  |                                   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 17 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>               |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Particular attention should be given to the instructions on the reverse of this certificate. The law requires that the death certificate be executed within 24 hours after death. Particular attention should be given to the instructions on the reverse of this certificate. The law requires that the death certificate be executed within 24 hours after death. Particular attention should be given to the instructions on the reverse of this certificate.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



NOV 1 1950

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80

27959

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>George K. Crist  |  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>11 28 80 |  |  | 2b HOUR<br>12:35 (M)  |  |
| 3 SEX<br>M  |  | 4 RACE<br>W  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>12 24 27  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>52 YRS.   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore   |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore Cancer Research Center |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>ENGINEER  |  | 12b KIND OF BUSINESS OR INDUSTRY<br>C & P TEL. CO.  |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE MD COUNTY BALTO. CITY OR TOWN GLEN ARM   |  |  |  | 13b INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13c STREET ADDRESS<br>11813 HARBORD RD.   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>HARRY W. CRIST   |  |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MILDRED KNOX   |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES  |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>KOREAN 219-28-10408  |  | 17 INFORMANT<br>ADDRESS<br>FAMILY  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Respiratory Failure</u><br>2000<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <u>Sepsis</u><br>(c) <u>Diffuse Hemolytic Lymphoma</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |  |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |   |  |
| 19a DATE OF OPERATION<br>11/1/80  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Hickman Catheter - Venous access  |  | 20a AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a I certify that (I) (this hospital) attended the deceased from <u>11/1/80</u> 19 <u>80</u> to <u>11/28</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>11/28</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                      |  |  |  |  |  |   |  |
| 22b SIGNATURE<br>Henry Gerard, M.D.<br>22b PHYSICIAN'S NAME (TYPE OR PRINT)<br>Henry Gerard M.D.  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |  | 22c DATE SIGNED<br>11/28/80   |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  |  |  | 23b DATE<br>DEC 2 1980   |  | 23c NAME OF CEMETERY OR CREMATORY<br>PARKWOOD   |  |
| 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO. COUNTY MD.  |  |  |  | 23e DATE REC'D. BY REGISTRAR<br>DEC 2 1980   |  |   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>C.F. EVANS   |  |  |  | 25a ADDRESS<br>8800 Harford Rd   |  |   |  |
| 25b REGISTRAR'S SIGNATURE<br>[Signature]  |  |  |  |  |  |   |  |

BP

DHMH-16 25M  
(VRA 15, 4) 1/79



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |         |  |                         |
|--|---------|--|-------------------------|
| 1. FOR<br>STATE<br>REGISTRAR   |         | 7. 0 2 7 9 6 0   |                         |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | 2. DATE KNOWN<br>OF DEATH  |                         |
| FIRST MIDDLE LAST<br>OLIVER Russell CROUSE, Jr.  |         | MONTH DAY YEAR HOUR<br>11 8 19 80 M  |                         |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   | 6. AGE (IN YEARS)       |
| male   | white   | MONTH DAY YEAR<br>March 3, 1923  | LAST BIRTHDAY<br>57 YRS |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |                         |
| Pennsylvania   |         | U.S.A.   |                         |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                         |
| Baltimore  |         | University Hospital  |                         |
| 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)   |         | 12b. KIND OF BUSINESS<br>OR INDUSTRY   |                         |
| Teacher  |         | Public School System   |                         |
| 13a. STATE   |         | 13b. COUNTY  |                         |
| Maryland   |         | Frederick  |                         |
| 13c. CITY OR TOWN  |         | 13d. INSIDE CITY LIMITS?   |                         |
| Frederick  |         | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                         |
| 13e. STREET ADDRESS  |         | 13f. CITY LIMITS?  |                         |
| 7904 Whitmer Court   |         | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                         |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME   |                         |
| FIRST MIDDLE LAST<br>Oliver Russell Crouse, St.  |         | FIRST MIDDLE LAST<br>Margaret Maryl Somers   |                         |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |         | 16b. SOCIAL SECURITY NO.   |                         |
| Yes  |         | W. W. II 218-14-0624   |                         |
| 17. INFORMANT  |         | 17a. ADDRESS   |                         |
| John F. Crouse, Baltimore, Md. 21204   |         | 8201 B Loch Raven Blvd.  |                         |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |         |  |                         |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |         |  |                         |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                         |
| 20. AUTOPSY?   |         | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                         |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         | 21b. TIME OF INJURY<br>HOUR XXX MONTH DAY YEAR<br>3:12 P.M. 11-8-19 80                                     |                         |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |         | Operator of motorcycle/auto collision.   |                         |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK  |         | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)<br>Road                                     |                         |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>U.S. Rt. 40 & Harmony Ellerton Rd. Frederick Md.  |         |  |                         |
| 22a. I certify that I took charge of the remains described above, held on<br>death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |         |  |                         |
| ACTUAL<br>SIGNATURE  |         | TITLE (SPECIFY)<br>Assistant   |                         |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |         | DATE<br>SIGNED   |                         |
| Ann M. Dixon, M.D.   |         | 11-9-80  |                         |
| ADDRESS  |         | 111 Penn St.   |                         |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |         | 23b. DATE  |                         |
| Burial   |         | Nov 13, 1980   |                         |
| 23c. NAME OF CEMETERY OR CREMATORY   |         | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |                         |
| New Cathedral Cemetery   |         | Baltimore, Maryland  |                         |
| 24. FUNERAL DIRECTOR<br>(NAME AND ADDRESS)   |         | 25a. DATE REC'D. BY REGISTRAR  |                         |
| Smith, Fadelley, Keeney, Basford Funeral Home<br>106 East Church St., Frederick, Md. 21701   |         | NOV 14 1980  |                         |
| 25b. REGISTRAR'S SIGNATURE   |         |  |                         |
|  |         |  |                         |

50

[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 7 9 6 1

FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |   |  |
|---|--|---|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Ollie O. Cunningham</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11/13/80</b> |   | 2b. HOUR<br>M<br><b>M</b>   |  |
| 3. SEX<br><b>Fe</b>   |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 17 17</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b>   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Va.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b><br>MD.   |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1122 Woodyear St.</b> |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Domestic</b> |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  |  |   |  |   |   |  |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   |   |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Balto.</b>  |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 13e. STREET ADDRESS<br><b>1122 Woodyear St.</b>   |  |   |  |   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Willis Swain</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Oney Smith</b>  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>215 28 7242</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Josephine Walker 2020 Hillenwood</b>  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>acute myocardial infarction</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Hypertensive Cardiovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>8 11 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>6/29/79</b> to <b>8/13/80</b> , that (I) (we) lost saw the deceased alive on <b>8/13/80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |   |  |
| 23a. SIGNATURE<br><b>Theo C. Patterson</b>  |  |   |  | 23b. DEGREE<br><b>M.D., P.A.</b>  |   | 23c. DATE SIGNED<br><b>11/18/80</b>  |
| 23d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>THEO. C. PATTERSON, M. D., P. A.</b>  |  |   |  | 23e. ADDRESS<br><b>2422 DUNDALK AVE</b>   |   |  |
| 23f. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23g. DATE<br><b>11/18/80</b>  |  | 23h. NAME OF CEMETERY OR CREMATORY<br><b>Crest Lawn, MD.</b>  |   | 23i. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>21222</b>   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Jas. A. Morton &amp; Sons 1701 Laurens</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 19 1980</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Patricia Helms</b>  |

100 V



3



NOV 1 1961

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 2 7 9 6 2  
CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |   |  |   |   |  |
|--|---|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Barbara</b> <b>Cupak</b>  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 10 80</b>                                |   | 2b. HOUR<br><b>11:12 AM</b>                      |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>Caucasian</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 18 24</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS MONTHS DAYS<br><b>57 0 0</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD    |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore City Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>House Wife</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b> |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>-</b> 13c. CITY OR TOWN <b>Baltimore</b> |   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>     |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles - Hennessey</b>   |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Emma - Gottstein</b>              |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>217-26-3678</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Theresa Zakens 508 S. Duncan St.</b> |  |

|   |  |  |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br><b>0400</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>hypoxia</b><br>(c) <b>pneumonia</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>seconds - mins. - hrs. - week</b> |
|---|--|--|

|   |   |  |  |
|---|---|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>Sepsis secondary to thigh gangrene</b>   |   |  |  |
| 19a. DATE OF OPERATION<br><b>10/16/80</b>   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Gas gangrene (R) thigh</b> | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK NOT AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)            | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/16/80</b> to <b>11/10/80</b> , that (I) (we) lost<br>saw the deceased alive on <b>11/10/80</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above; (I) (we) (did) (did not) view the body after death. |   |  |  |
| 22b. SIGNATURE<br><b>Julia Haller Go MD</b>   |   | DEGREE<br><b>MD</b>  | 22c. DATE SIGNED<br><b>11/10/80</b>  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JULIA H. YEO</b>  |   | 22e. ADDRESS<br><b>Balto. City Hospital</b>  |  |

|  |                                   |   |   |
|--|-----------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                  | 23b. DATE<br><b>Nov. 14, 1980</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Rosary Cemetery</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>- - Baltimore Co., Md.</b> |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Lilly &amp; Zeiler Inc. 1901 Eastern Ave./21231</b> |                                   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 12 1980</b>               | 25b. REGISTRAR'S SIGNATURE<br><b>Barbara Cupak</b>                          |

1994

• • •

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 months after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 27963

REG. NO.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Vernon Currier</b>   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 15, 1980</b>   |  | 2b. HOUR<br><b>2:23A M</b>   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Cau.</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 14 1904</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Baltimore</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Theater</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Owner Manger</b>   |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>-----</b>   |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Merriman Currier</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.<br><b>216 - 07 - 0272 -</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Chorazine Currier 3613 Hickory Ave. 21211</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infraction</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (X) (this hospital) attended the deceased from <b>November 11, 1980</b> to <b>November 15, 1980</b> , that (X) (we) last saw the deceased alive on <b>November 15, 1980</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (X) (we) (did) (did not) view the body after death.                      |  |   |  |   |  |  |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Craig Martin, M.D.</b>   |  |   |  | 22c. DATE SIGNED<br><b>11-15-80</b>   |  | 22d. ADDRESS<br><b>c/o Maryland General Hospital</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>11 - 18 - 80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto ----- Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Burgee Funeral Home</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 17 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |

10-10-54

10-10-54

10-10-54

10-10-54



10-10-54

10-10-54

10-10-54

10-10-54

10-10-54

10-10-54

10-10-54

10-10-54

10-10-54

10-10-54

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80

27964

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |   |  |   |                            |  |  |
|--|--|---|--|---|----------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Anthony Dalfonzo</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 17 1980</b> |   | 2b. HOUR<br><b>8:35 PM</b> |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Feb. 12, 1893</b>  |                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>87</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Italy</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST AGNES HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Barber</b>   |                            | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Barber</b>   |  |
| 13a. STATE<br><b>Maryland</b>  |  |   |  | 13b. CITY OR TOWN<br><b>Catonsville</b>   |                            | 13c. STREET ADDRESS<br><b>126 S. Symington Ave.</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Giuseppe Dalfonzo</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Vincenzo (unknown)</b>  |                            |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>212-34-8999A</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Jenny Dalfonz, 126 S. Symington Ave.</b>  |                            |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary Edema + Pneumonia</b><br>5183 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pulmonary Interstitial Infiltrate</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASCVD</b> |  |   |  |   |                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |  |   |                            |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |                            |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                            |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |                            |  |  |
| 22b. SIGNATURE<br><b>Victor Jaworsky</b>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |                            | 22c. DATE SIGNED<br><b>11/17/1980</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Victor Jaworsky</b>  |  |   |  | 22e. ADDRESS<br><b>St. Agnes Hospital<br/>900 Caton Avenue, Baltimore, Maryland</b>   |                            |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11/20/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral Cem</b>  |                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Witzke Funeral Home of Catonsville, P.A. 21228</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 18 1980</b>   |                            | 25b. REG. STAMP'S SIGNATURE<br><b>Ruby McBrady</b>   |  |

THIS DOCUMENT

IS A REPRODUCTION

OF THE ORIGINAL



NOV 18 1964



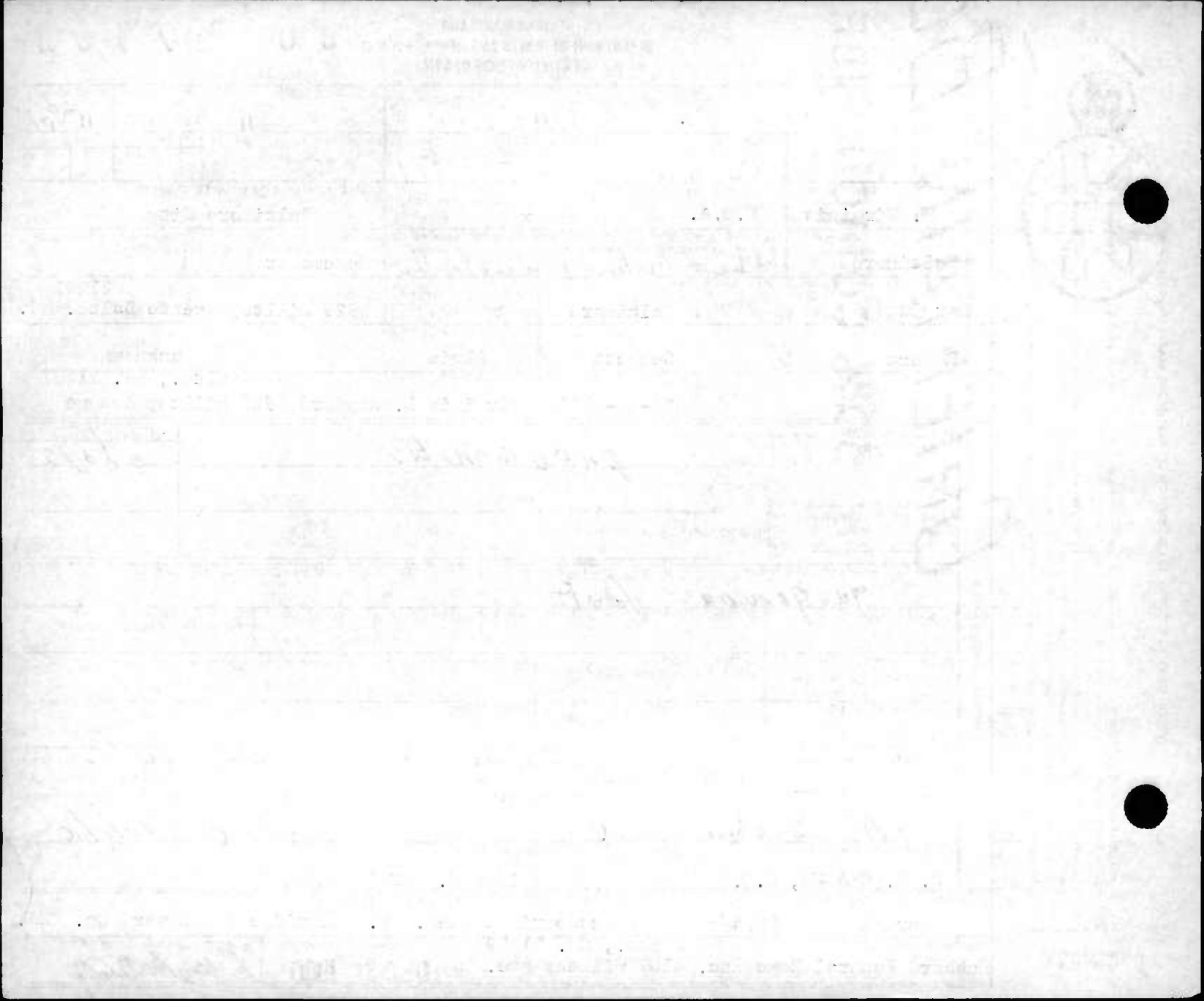
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 7 9 6 5

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>MYRTLE M. DANNER  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>11 30 80   |  | 2b. HOUR<br>11 <sup>20</sup> PM   |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>2 3 1894   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>W. Virginia   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>John L. Newton Medical Center           |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore   |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Robert D Beckett  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Algia unknown  |  | 13d. STREET ADDRESS<br>5929 Hilltop Avenue Balto. Md. 21207   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>429-48-9714   |  | 17. INFORMANT ADDRESS Balto., Md. 21207<br>Virginia L. Sanford 5929 Hilltop Avenue  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>pneumonia</u><br>4860<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 days  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>24g infections food</u>  |  |  |  |   |  |
| 19a. DATE OF OPERATION<br><u>4/29/80</u>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that <del>this</del> (this hospital) attended the deceased from <u>4/29</u> 19 <u>80</u> , to <u>4/30</u> 19 <u>80</u> , that <del>we</del> (we) last saw the deceased alive on <u>4/30</u> 19 <u>80</u> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>in</del> (we) (did) <del>(did not)</del> view the body after death. |  |  |  |   |  |
| 22b. SIGNATURE<br><u>J.R. Gladue, MD</u>   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><u>12/1/80</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>J. R. GLADUE, M.D.  |  | 22e. ADDRESS<br>1000 S. CATON AVENUE   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>12/4/80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowridge Mem. Pk.  |  |
| 23d. LOCATION<br>(CITY OR TOWN)<br>Elkridge  |  | COUNTY<br>Howard Co.   |  | STATE<br>Md.  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Hubbard Funeral Home Inc.  |  | BALTO., Md. 21229<br>4107 Wilkens Ave.   |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 3 1980   |  |
|  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

80 27966

|  |  |  |   |   |                       |   |  |  |  |   |  |
|--|--|--|---|---|-----------------------|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST: Angela MIDDLE: Ellen LAST: Daniel  |  |  | 2a. DATE OF DEATH<br>MONTH: 11 DAY: 17 YEAR: 80 |   | 2b. HOUR<br>7:45 P.M. |   |  |  |  |   |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>WHITE   |   | 5. DATE OF BIRTH<br>MONTH: 02 DAY: 04 YEAR: 14  |                       | 6. AGE (IN YEARS LAST BIRTHDAY)<br>66 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS: DAYS: HOURS: MIN.   |  | IF UNDER 24 HRS.<br>HOURS: MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST AGNES HOSPITAL |   |   |                       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE                   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |   |   |                       |   |  |  |  |   |  |
| 13a. STATE<br>Md.  |  | 13b. COUNTY<br>Balto.  |   | 13c. CITY OR TOWN<br>Landsdowne   |                       | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>35 Third Ave.   |  |   |  |
| 14. FATHER'S NAME<br>FIRST: John MIDDLE: Klosterman LAST: Klosterman   |  |  |   |   |                       | 15. MOTHER'S MAIDEN NAME<br>FIRST: Margaret MIDDLE: Lavin LAST: Lavin                           |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>214 46 0995  |                       | 17. INFORMANT<br>ADDRESS<br>Charles H. Daniel same as 13 e                                      |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardio Pulmonary Arrest.<br>4960<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Respiratory Failure<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Chronic Obstructive Pulmonary Disease      |  |  |   |   |                       |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>Acute Myocardial Infarction Bowel Obstruction Acute Renal Failure   |  |  |   |   |                       |   |  |  |  |   |  |
| 19a. DATE OF OPERATION<br>11-16-80   |  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Bowel Obstruction   |                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                       | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov 6, 1980 to Nov 17, 1980, that (I) (we) last saw the deceased alive on Nov 17, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. |  |  |   |   |                       |   |  |  |  |   |  |
| 22b. SIGNATURE<br>Oscar Hernandez  |  |  |   |   |                       | DEGREE<br>M.D.  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>11-17-80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Oscar Hernandez   |  |  |   |   |                       | 22e. ADDRESS  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |  |   | 23b. DATE<br>11/21/80   |                       | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cem  |  | 23d. LOCATION<br>CITY OR TOWN: Brooklyn COUNTY: A.A. STATE: Md.  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME: George J. Gonce ADDRESS: 4001 Ritchie Hgwy. Balto 21225  |  |  |   |   |                       | 25a. DATE REC'D. BY REGISTRAR<br>NOV 21 1980  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled in by the funeral director within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



BALTIMORE CITY

ST. JOSEPH HOSPITAL

BALTIMORE

NOV 1 1960

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80

27967

REG. NO.

|  |  |   |  |  |                                    |  |   |  |   |  |  |
|--|--|---|--|--|------------------------------------|--|---|--|---|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>ELIZABETH</b>                            |  |   | FIRST MIDDLE LAST <b>DARGAN</b>                                      |  |                                    | 2a. DATE OF DEATH MONTH DAY YEAR <b>11 1 80</b>                                    |   |  | 7b. HOUR <b>10:05 PM</b>  |  |  |
| 3 SEX <b>F</b>   |  | 4 RACE <b>B</b>   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR <b>6 11 43</b>   |                                    |  | 6 AGE (IN YEARS LAST BIRTHDAY) <b>37</b>  |  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>S.C.</b>                          |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    |  | 9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALT. CITY</b> MD.                                       |  |   |  |  |
| 10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BON SECOURS HOSPITAL</b> |  |  |                                    | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) <b>UNEMPLOYED</b> |   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                     |  |  |
| 13a. STATE <b>MD</b>   |  |   | 13b. COUNTY  |  | 13c. CITY OR TOWN <b>Baltimore</b> |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>2860 W. GARRISON</b><br><b>BALT. MD. 21215</b> |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST <b>JOSEPH</b>                            |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>SELENA BRISBANE</b> |  |                                    |  |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b> |  |   | 16b. SOCIAL SECURITY NO. <b>142-34-8399</b>                          |  |                                    | 17 INFORMANT ADDRESS <b>Cleveland Dargan 3701 Howard Pk. Ave</b>                   |   |  |   |  |  |

|   |  |   |  |
|---|--|---|--|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY. |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b>   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <b>SEPSIS</b>  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <b>RENAL FAILURE</b>   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF <b>NEPHROSCLEROSIS</b>   |  |   |  |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) **HYPERTENSION & DIABETES**

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1 NOV</b> 19 <b>80</b> to <b>1 NOV</b> 19 <b>80</b> , that (I) (we) lost<br>saw the deceased alive on <b>1 NOV</b> 19 <b>80</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Curtis E Davis</b>   |  | DEGREE <b>MD</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>3 NOV</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CURTIS E DAVIS</b>  |  | 22e. ADDRESS<br><b>Bon Secours Hosp</b>                                |  |  |  |  |  |

|   |  |                          |  |  |  |   |  |
|---|--|--------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>                            |  | 23b. DATE <b>11/6/80</b> |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Ceme.</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co. MD</b> |  |
| 24 FUNERAL DIRECTOR<br>NAME <b>Wm. C. March F/H</b> ADDRESS <b>1101 E. North Ave.</b> |  |                          |  | 25a. DATE REC'D. BY REGISTRAR <b>NOV 5 1980</b>            |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                      |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 7 9 6 8

REG. NO.

|  |   |  |   |  |  |
|--|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ELIJAH DAVIS</b>  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 18 80</b>  |  | 2b. HOUR<br>M<br><b>11</b>   |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>Male</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 2 22</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS MONTHS DAYS<br><b>58</b>                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>South Carolina</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>               |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD               |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1114 N. Fulton Ave.</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>  | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>Baltimore</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>1114 N. Fulton Ave.</b>                              |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>- - -</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>- - -</b>  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>248-28-0771</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Rosella Davis 11 N. Schroeder St.</b>           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4254</b> IMMEDIATE CAUSE (a) <b>Congestive heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>Cardio myopathy</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Seizure disorder, sexual abuse</b>   |   |  |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9/28/80</b> to <b>10/15/80</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |   |  |   |  |  |
| 22b. SIGNATURE<br><b>Rifat Aboumy</b>  |   | DEGREE <b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Rifat Aboumy</b>   |   | 22e. ADDRESS<br><b>2300 Carrison Blvd</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |   | 23b. DATE<br><b>11/24/80</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Calvary cem</b>                   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co. MD</b>  |   | 23e. DATE REC'D. BY REGISTRAR<br><b>NOV 25 1980</b>  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>  |   | ADDRESS<br><b>1101 E. North Ave.</b>   |   | 25. REGISTRAR'S SIGNATURE<br><b>Rifat Aboumy</b>                               |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



*[Handwritten signature]*

1404 2 1930



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                      |  |  |  |   |  |  |  | REG. NO. 27969  |  |
|---|--|----------------------|--|--|--|---|--|--|--|---|--|
| 1- STATE REGISTRAR  |  |                      |  |  |  |   |  |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>James H. Davis</b>  |  |                      |  |  |  |   |  |  |  | 2b. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> HOUR <input type="checkbox"/> MIN. <b>11 15 19 80</b> |  |
| 3. SEX <b>Male</b>  |  | 4. RACE <b>Black</b> |  | 5. DATE OF BIRTH MONTH <b>6</b> DAY <b>24</b> YEAR <b>1920</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>60 YRS.</b>  |  | IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>   |  | IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>   |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  |  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Disabled</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE <b>Md</b>  |  |                      | 13b. COUNTY  |  |  | 13c. CITY OR TOWN <b>Balto.</b>   |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 13e. STREET ADDRESS <b>3340 Clifton Ave.</b>  |  |                      | 14. FATHER'S NAME FIRST <b>Unknown</b> MIDDLE <b>Unknown</b> LAST <b>Unknown</b> |  |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Unknown</b> MIDDLE <b>Unknown</b> LAST <b>Unknown</b> |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>   |  |                      |  | 16b. SOCIAL SECURITY NO. <b>226 12 1714</b>  |  |   |  | 17. INFORMANT ADDRESS <b>Thelma Davis 10 N. Hilton St.</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY: <b>Alcoholism</b><br>IMMEDIATE CAUSE (a) <b>3030</b> <b>Alcoholism</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. <b>DOE TO, OR AS A CONSEQUENCE OF</b><br>(b) <b>DOE TO, OR AS A CONSEQUENCE OF</b><br>(c)  |  |                      |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |                      |  |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                      |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |   |  | 21f. LOCATION CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                      |  |  |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE <b>Margarita A. Korell</b>   |  |                      |  |  |  | TITLE (SPECIFY) <b>Assistant</b> MEDICAL EXAMINER                                       |  |  | DATE SIGNED <b>11-16-80</b>  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>  |  |                      |  |  |  | ADDRESS <b>111 Penn Street</b>  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  |                      |  | 23b. DATE <b>11-20-80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Crownsville V. A. Cem</b>                         |  |  |  | 23d. LOCATION CITY OR TOWN <b>Crownsville</b> COUNTY <b>Md.</b> STATE   |  |
| 24. FUNERAL DIRECTOR NAME <b>Brown/Thompson F. H.</b> ADDRESS <b>1913 W. Balto. St.</b>   |  |                      |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>NOV 18 1980</b>  |  |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>  |   |  |

C-12

1

5. *STY*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 27970

REG. NO.

3  
1. FOR  
STATE  
REGISTRAR

|   |   |   |  |   |  |
|---|---|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Figgie Watts</i>  |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>Nov, 30, 80</i>             |   | 2b. HOUR<br><i>6:45 AM</i>   |
| 3. SEX<br><i>Female</i>   | 4. RACE<br><i>Black</i>   | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>6 20 1898</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>82 years</i>  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Virginia</i>  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.</i>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.                               |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore City</i>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Lincoln Convalescent Center</i> |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i></i>                        |  |
| 13a. STATE<br><i>Maryland</i>   |   | 13b. COUNTY<br><i>Baltimore</i>   | 13c. CITY OR TOWN<br><i>Baltimore</i>                              | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>Jack Taylor</i>   |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Easter Cleman</i> |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |   | 16b. SOCIAL SECURITY NO.<br><i>239-48-2022</i>  |  | 17. INFORMANT ADDRESS<br><i>Healia Miles 1608 E. Biddle St 21213</i>                            |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Acute M.I.</i><br>2819<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>Chr. Anemia</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i></i><br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>sudden onset.</i> |   |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |   |   |  |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>March 20, 1979</i> to <i>Nov 30, 1980</i> that (I) (we) lost saw the deceased alive on <i>Nov 29, 1980</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |   |   |  |   |  |
| 22b. SIGNATURE<br><i>A. C. Baykaler</i>   |   | DEGREE<br><i>M.D.</i>   |  | 22c. DATE SIGNED<br><i>11-30-80</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>A-C. BAYKALER, M.D.</i>   |   | 22e. ADDRESS<br><i>3459 St. Johns Lane, Ellicott City, Md.</i>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>  |   | 23b. DATE<br><i>.12/4/80</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Church Cemetery</i>                                    |  |
| 23d. LOCATION CITY OR TOWN<br><i>Seaboard, N.C.</i>   |   | COUNTY<br><i></i>   |  | STATE<br><i></i>  |  |
| 24. FUNERAL DIRECTOR NAME<br><i>Wm C March F/H</i>  |   |   | ADDRESS<br><i>1101 E. North Ave.</i>                               |   |  |
| 25a. DATE REC'D. BY REGISTRAR<br><i>DEC 2 1980</i>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>Patricia Mabury</i>  |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 7 9 7 1

REG. NO.

FOR  
STATE  
REGISTRAR

|   |   |  |  |  |  |                            |   |                                    |                          |
|---|---|--|--|--|--|----------------------------|---|------------------------------------|--------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |   | FIRST  | MIDDLE   | LAST   | 2a. DATE OF DEATH  | MONTH                      | DAY   | YEAR                               | 2b. HOUR                 |
| LOUISE R DAVIS  |   |  |  |  | 11-1-80  |                            |   |                                    | 4:20A                    |
| 3. SEX  | 4. RACE   | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR            |   | IF UNDER 24 HRS                    |                          |
| F   | BLACK   | MONTH DAY YEAR<br>12 18 1989   |  | 90   |  | MONTHS DAYS                |   | HOURS MIN.                         |                          |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |                            |   |                                    |                          |
| VIRGINIA  | USA   |  |  | BALTO CITY   |  |                            |   |                                    |                          |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY                        |                            |   |                                    |                          |
| BALTO   | Provident Hosp 2600 LIEBOWITZ HEIGHTS AVE   |  | NURSE  |  | Hospital   |                            |   |                                    |                          |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |   | 13a. STATE   |  | 13b. COUNTY  | 13c. CITY OR TOWN  |                            | 13d. INSIDE CITY LIMITS?  |                                    | 13e. STREET ADDRESS      |
|   |   | MD   |  |  | BALTO  |                            | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                    | 4001 CLARKS LANE APT 408 |
| 14. FATHER'S NAME   |   | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)           |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT                      |                          |
| ALBERT  |   | HOWSIA   |  | NO   |  | 130-03-6755A               |   | Mrs. S. Fletcher                   |                          |
|   |   |  |  |  |  |                            |   | ADDRESS 4001 CLARKS LA             |                          |
|   |   |  |  |  |  |                            |   | BALTO, MD 21215                    |                          |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Acute Pulmonary Edema<br>DUETO, OR AS A CONSEQUENCE OF (b) Left Ventricular Failure<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUETO, OR AS A CONSEQUENCE OF (c) |   |  |  |  |  |                            |   |                                    |                          |
| PART 2. OTHER SIGNIFICANT CONDITION CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) Anemia  |   |  |  |  |  |                            |   |                                    |                          |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?  |                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |                                    |                          |
|   |   |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/> |                            | YES <input type="checkbox"/> NO <input type="checkbox"/>            |                                    |                          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |                            |   |                                    |                          |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET  |  | CITY OR TOWN               |   | COUNTY                             | STATE                    |
|   |   |  |  |  |  |                            |   |                                    |                          |
| 22. I certify that (I) (this hospital) attended the deceased from 10-29-80 to 11-1-80, that (I) (we) last saw the deceased alive on 11-1-80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.   |   |  |  |  |  |                            |   |                                    |                          |
| 22b. SIGNATURE  |   | DEGREE   |  | 22c. DATE SIGNED   |  |                            |   |                                    |                          |
| D.N. DAS  |   |  |  |  |  |                            |   |                                    |                          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |   | 22e. ADDRESS   |  | 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)                                   |  | 23b. DATE                  |   | 23c. NAME OF CEMETERY OR CREMATORY |                          |
|   |   |  |  | Burial   |  | 1/3/80                     |   | Cedar Hill                         |                          |
|   |   |  |  | 23d. LOCATION<br>CITY OR TOWN  |  | COUNTY                     |   | STATE                              |                          |
|   |   |  |  | Baltimore  |  | AA, Co.                    |   | Md.                                |                          |
| 24. FUNERAL DIRECTOR<br>NAME  |   | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE |   |                                    |                          |
| Chatman J/H   |   | 1701 McCulloch St  |  | NOV 3 1980   |  | [Signature]                |   |                                    |                          |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 7 9 7 2

FOR  
1- STATE  
REGISTRAR

REG. NO.

|  |  |   |  |  |   |   |                                  |   |  |
|--|--|---|--|--|---|---|----------------------------------|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>MILDRED L. DAVIS</b>   |  |   | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 12, 1980</b> |  | 2b HOUR<br>M<br><b>A</b>  |   |                                  |   |  |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>Negro</b>  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 5 23</b>   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>YRS MONTHS DAYS<br><b>57</b>  |                                  |   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VA</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD   |                                  |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1316 N. Bond St.</b> |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |   | 12b KIND OF BUSINESS OR INDUSTRY |   |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br><b>MD</b>  |  | 13b COUNTY<br><b>Baltimore</b>  |  | 13c CITY OR TOWN<br><b>Baltimore</b>   |   | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |                                  | 13e STREET ADDRESS<br><b>1316 N. Bond St.</b> |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Wilbert Shields</b>  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Catherine Shields</b>  |  |  |   |   |                                  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>218-12-8788</b>  |  | 17 INFORMANT ADDRESS<br><b>William Davis 1316 N. Bond St.</b>  |   |   |                                  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u><br><b>4255</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <u>Longstanding Heart Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Alcoholic Cardiomyopathy</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Sudden</u><br><u>18 months</u><br><u>3 years</u> |  |   |  |  |   |   |                                  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Premature Ventricular Contractions</u>  |  |   |  |  |   |   |                                  |   |  |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                  |   |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |                                  |   |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |                                  |   |  |
| 22a I certify that (I) (this hospital) attended the deceased from <u>September 19, 79</u> to <u>November 12, 80</u> , that (I) (we) last saw the deceased alive on <u>November 12, 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |   |   |                                  |   |  |
| 22b SIGNATURE<br><u>Thomas A. Pearson M.D.</u>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |   | 22c DATE SIGNED<br><u>11/14/80</u>  |                                  |   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Thomas A. Pearson M.D.</u>  |  |   |  | 22e ADDRESS<br><u>Johns Hopkins Hospital</u>   |   |   |                                  |   |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b DATE<br><b>11/18/80</b>   |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Cem.</b>   |   | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore MD</b>  |                                  |   |  |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H 1101 E. North Ave.</b>  |  |   |  | 25a DATE REC'D. BY REGISTRAR<br><b>NOV 19 1980</b>   |   | 25b REGISTRAR'S SIGNATURE<br><u>Robert M. Brady</u>   |                                  |   |  |

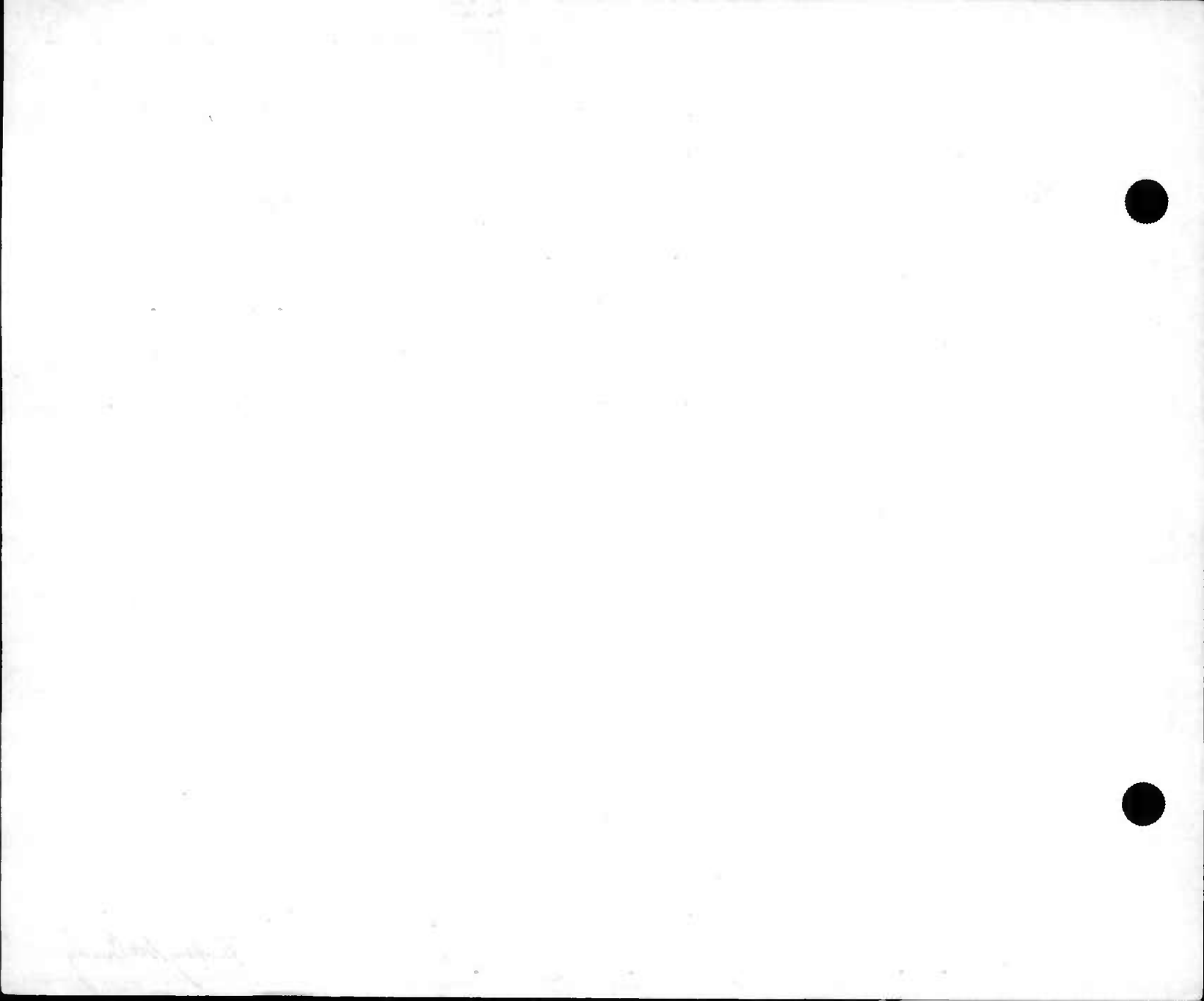
BP

DHMH-16 20M  
(VRA 15, 4) 7/78

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 833-3001.





Item 17 g549 11/21/80 gj

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

2 7 9 7 3

REG. NO.

FOR  
1. STATE  
REGISTRAR

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Nettin C. Davis</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11-12-80</b>                    |  | 2b. HOUR<br><b>2:30 AM</b>   |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>Negro</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 25 00</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS.<br>IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N.C.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Union Memorial Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)          |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br><b>MD</b>   |  |   | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>Baltimore</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Croom</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Georgianna Dupree</b> |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>239-12-9945</b>  |   | 17. INF. <b>Malvin</b> ADDRESS<br><b>Malvin Brown 1008 E. 43rd. St.</b>                                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Smear arrest</b><br><b>4275</b> DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Brainstem dysfunction + seizures</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Hypoxia 20' to original cardiac arrest</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                    | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>11/11 19 80</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/11 19 80</b> to <b>11/12 19 80</b> , that (I) (we) last saw the deceased alive on <b>11/12 19 80</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.   |  |   |   |  |  |
| 22b. SIGNATURE<br><b>D. Carroll</b>   |  | DEGREE  |   | 22c. DATE SIGNED<br><b>11/12/80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CARROLL</b>   |  | 22e. ADDRESS<br><b>UMH</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11/15/80</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holly Grove Cem.</b>             |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Lenior Co. N.C.</b>   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b> ADDRESS<br><b>1101 E. North Ave.</b>  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 12 1980</b>                       |  | 25b. REGISTRAR'S SIGNATURE<br><b>Rosby McCready</b>  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Navis

C.

Hettie

Baltimore City

Baltimore Memorial Hospital

Baltimore

NOV 1 1980

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 7 9 7 4

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST NORMAN MIDDLE S. LAST DAVIS<br><i>Norman S. DAVIS</i> |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>11-4-80                                       |  | 2b. HOUR<br>2:35 P.M.   |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>MONTH NOV. DAY 18, YEAR 1898  |  |
| 6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARried <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  | 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SINAI HOSPITAL   |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>RETAIL                         |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>SHOES  |  | 13a. STREET ADDRESS<br>APT. 202<br>6318 GREENSPRING AVE. #21209   |  |
| 14. FATHER'S NAME<br>FIRST DAVID MIDDLE LAST DAVIS   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST ETTA MIDDLE NITZEN                              |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) NO   |  |
| 16b. SOCIAL SECURITY NO.<br>239-01-9887  |  | 17. INFORMANT<br>MRS. BESS DAVIS 6318 GREENSPRING AVE., APT. 202 balto., md 21209 |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Varicella Pneumonia</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cor. Art. Disease</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>MSCVD</i> |  |

## MEDICAL CERTIFICATION

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11(a)

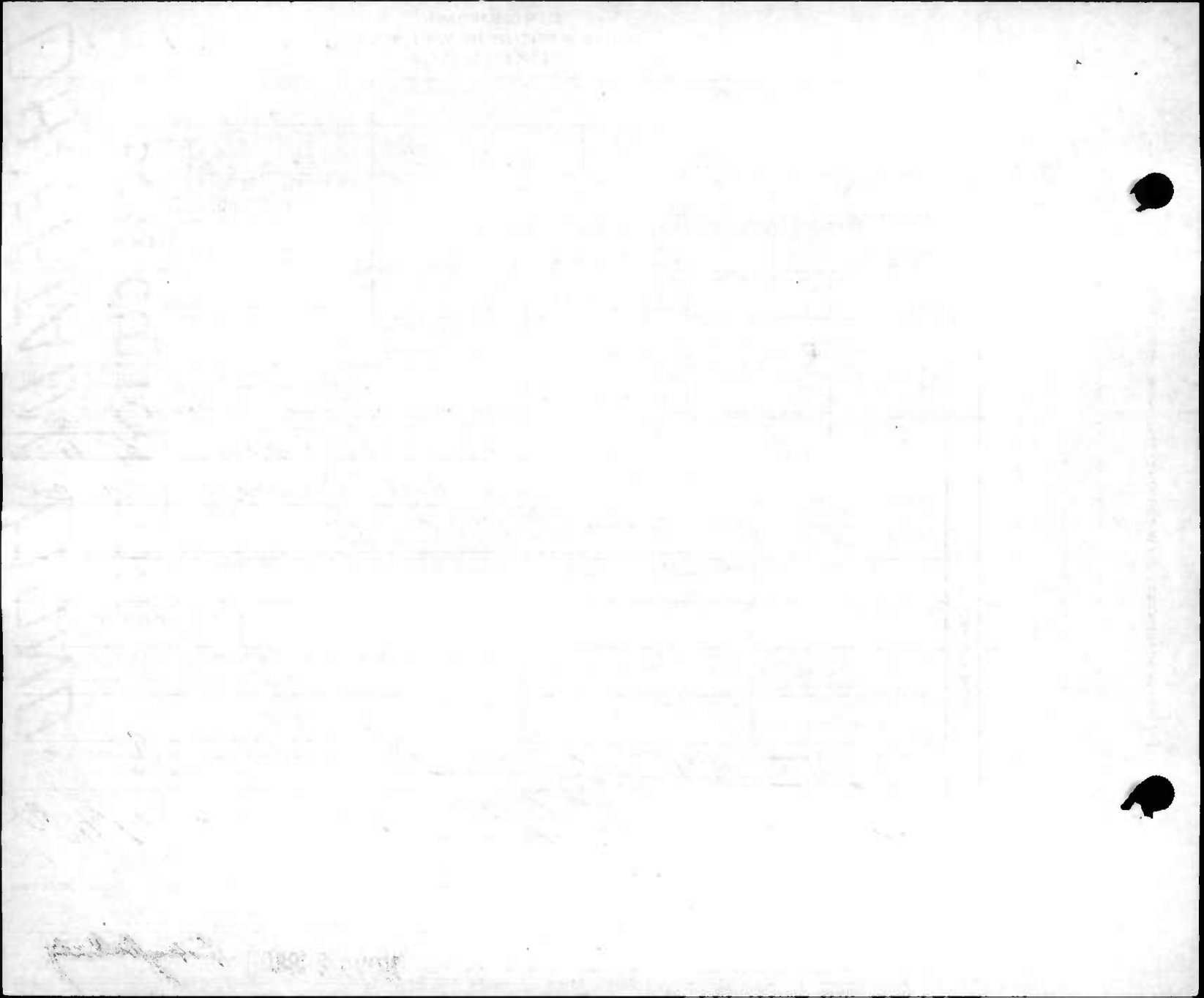
|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 22a. I certify that (I) (this hospital) attended the deceased from <i>11/4</i> 19 <i>80</i> , to <i>11/4</i> 19 <i>80</i> , that (I) <i>did</i> lost saw the deceased alive on <i>11/4</i> above, (I) <i>did</i> (did not) view the body after death. |  | 22b. SIGNATURE<br><i>Raymond H. Caplan</i> |  | 22c. PHYSICIAN'S NAME (TYPE OR PRINT)<br>RAYMOND CAPLAN, M.D.   |  |
| 22d. DATE SIGNED<br>11/4/80   |  | 22e. ADDRESS<br>SINAI HOSPITAL             |  | 22f. DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 23a. BURIAL CREMATION, REMOVAL (SPECIFY)<br>BURIAL                   |  | 23b. DATE<br>11/6/80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>OHEB SHALOM |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>REISTERSTOWN BALTO. MD |  | 24. FUNERAL DIRECTOR<br>NAME SOL LEVINSON & BROS., INC.<br>ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215 |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 12 1980      |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 2 7 9 7 5  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Ruth M. Davis</b>   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11-25-80</b>                                      |  | 2b. HOUR<br><b>8:20 AM</b>   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10-13-13</b>                          |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS.  |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                     |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                           |  | 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                  |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Good Samaritan Hosp.</b>   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Registered Nurse</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>3301 Moravia Road</b>   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Lewis Charles Scheper</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Josephine Gries</b>                     |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.<br><b>219--20-6562A</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Mr. James R. Davis same</b>                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b><br><b>4360</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Re. Stroke</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                      |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (1) this hospital attended the deceased from <b>Nov. 15</b> 19 <b>80</b> , to <b>Nov. 25</b> 19 <b>80</b> , that (1) <b>yes</b> last saw the deceased alive on <b>Nov. 25</b> 19 <b>80</b> , and that in (my) <b>own</b> opinion death occurred on the date and hour and from the causes stated above; (2) <b>yes</b> (and) did not view the body after death. |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Jung-sin Lee</b> M.D.   |  |   |  | 22c. DATE SIGNED<br><b>Nov. 25, 1980</b>                                       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JUNG-SIN LEE</b>   |  |   |  | 22e. ADDRESS<br><b>The Good Samaritan Hosp.</b>                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>Nov. 26, 1980</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GreenMount</b>                        |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 26 1980</b>   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Leonard J. Ruck Inc. Baltimore, Maryland</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Fitzpatrick</b>  |  |  |  |

35  
43  
35  
300  
1

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten signature or initials

NOV 8 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9:55A

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>WILLIAM A. DAVIS</b>  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 11 1980</b>   |  | 2b HOUR<br><b>9:55AM</b>   |  |
| 3. SEX<br><b>M</b>  | 4. RACE<br><b>Black</b>                    | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 16 25</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>54</b> YRS.                                    |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>N.C.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Church Homes &amp; Hosp.</b>                |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Balto.</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Dave Davis</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Doll Green</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>243-40-4311</b>  |  | 17. INFORMANT ADDRESS<br><b>Eleanor Matthews 43 N. Eden St.</b>                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b><br><b>2501</b> DUE TO, OR AS A CONSEQUENCE OF <b>CARDIOGENIC SHOCK</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>cardiorespiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>DIABETIC KETOACIDOSIS</b><br><b>Diabetic Ketoacidosis</b><br>PART II. OTHER CAUSES OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br><b>G.I. Bleeding - Renal failure</b> |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11-47</b> 19 <b>80</b> , to <b>11-55</b> 19 <b>80</b> , that (I) (we) most saw the deceased alive on <b>11-55</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>F. Khwaja</b>  |  | DEGREE  |  | 22c. DATE SIGNED<br><b>11-5-80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>TAHOORA KHWAJA M.D.</b>   |  | 22e. ADDRESS<br><b>CHURCH HOSPITAL CORPORATION<br/>100 N. BROADWAY, BALTIMORE, MD 21231</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>11/10/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Cem.</b>                          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm C March F/H</b>   |  | ADDRESS<br><b>1101 E. North Ave.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 10 1980</b>                                  |  |
|   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Dorothy McRuddy</b>                                 |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.FOR  
1. STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

27977

|   |  |  |  |   |   |  |
|---|--|--|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>IRMA L. DEAL</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11/26/80</b> |   | 2b. HOUR<br>MIN.<br><b>1:20 A.M.</b>                            |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct. 10, 1892</b>  |   |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>88</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.   |  | 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b>                 |   |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |  | 13a. STREET ADDRESS<br><b>1509 Oakridge Road</b>  |   |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Samuel B. K. Lambdin</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Sarah Dorsey</b>  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>220 48 6499</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs. J. Scott Shugars</b><br><b>Same</b>   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Right cerebrovascular accident</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br><b>4360</b> |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hours</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  |   |   |  |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Nov. 25</b> , 19 <b>80</b> , to <b>Nov. 26</b> , 19 <b>80</b> , that (I) (we) lost<br>saw the deceased alive on <b>Nov. 25</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.     |  |  |  |   |   |  |
| 22b. SIGNATURE<br><b>Victoria M. Woolston MD</b>  |  |  |  | 22c. DATE SIGNED<br><b>11/26/80</b>   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Victoria M. Woolston MD</b>   |  |  |  | 22e. ADDRESS<br><b>Union Memorial Hospital</b>  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>11/29/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount</b>  |   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto., Md.</b>  |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Henry W. Jenkins &amp; Sons Co.</b><br><b>4905 York Road Balto., Md. 21212</b>                                |  |   |   |  |
| 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 28 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |   |   |  |

MEDICAL CERTIFICATION

29



For In

File

Oct. 10, 1886

By

U. A.

WILLIAM PETERSON HOSPITAL

Hospital

Two Hours

Married

E. J. Jones

1886

Samuel

E. J. Jones

Married

Donor

No

See also page Mrs. J. Scott Jones

Green Mount

W. J. Jones & Sons Co.

Mo. 21212

Expo.

Nov 2 1880

*Handwritten signature*

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
15M2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |                              |                  |  |                |                  |   |          |  |
|--|------------------------------|------------------|--|----------------|------------------|---|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |                              |                  | 2a. DATE KNOWN<br>OF DEATH   |                |                  | 2b. HOUR  |          |  |
| Edward W Deaver  |                              |                  | MONTH DAY YEAR<br>11 26 80   |                |                  | PM  |          |  |
| 3. SEX   | 4. RACE                      | 5. DATE OF BIRTH | 6. AGE (IN YEARS)  | IF UNDER 1 YR. | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD  | 2d. HOUR |  |
| male   | white                        | 3-23-16          | 64 YRS.  | MONTHS DAYS    | HOURS MIN.       | MONTH DAY YEAR<br>11 26 80  | 1:33 PM  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY? |                  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |                |                  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |          |  |
| Balto. City  | U.S.A.                       |                  |  |                |                  | Baltimore City  |          |  |
| 10. CITY OR TOWN OF DEATH  |                              |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)   |                |                  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |          |  |
| Baltimore  |                              |                  | 5610 Anthony Avenue  |                |                  | Meat Cutter   |          |  |
| 12b. KIND OF BUSINESS OR INDUSTRY  |                              |                  | 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |                |                  | 13b. COUNTY   |          |  |
| Retired  |                              |                  | 13a. STATE   |                |                  | 13c. CITY OR TOWN   |          |  |
|  |                              |                  | Md.  |                |                  | Balto.  |          |  |
| 14. FATHER'S NAME  |                              |                  | 15. MOTHER'S MAIDEN NAME   |                |                  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)         |          |  |
| William E. Deaver  |                              |                  | Ellie Cunningham   |                |                  | Yes   |          |  |
| 16b. SOCIAL SECURITY NO.   |                              |                  | 17. INFORMANT  |                |                  | 17b. ADDRESS  |          |  |
| 220-07-2622  |                              |                  | Mrs. Dorothy R. Deaver   |                |                  | 21206   |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:   |                              |                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |                |                  |   |          |  |
| 4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease   |                              |                  |  |                |                  |   |          |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |                              |                  | DUE TO, OR AS A CONSEQUENCE OF   |                |                  |   |          |  |
|  |                              |                  | DUE TO, OR AS A CONSEQUENCE OF   |                |                  |   |          |  |
|  |                              |                  | DUE TO, OR AS A CONSEQUENCE OF   |                |                  |   |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).                            |                              |                  |  |                |                  |   |          |  |
| 19a. DATE OF OPERATION   |                              |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                |                  | 20. AUTOPSY?  |          |  |
|  |                              |                  |  |                |                  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |          |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                      |                              |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |                |                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> |                              |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |                |                  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |          |  |
| 22a. I certify that I took charge of the remains described above, held an  |                              |                  | Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/>   |                |                  | and in my opinion   |          |  |
| death resulted from:   |                              |                  | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                |                  |   |          |  |
| ACTUAL SIGNATURE   |                              |                  | TITLE (SPECIFY)  |                |                  | DATE SIGNED   |          |  |
| Margarita A. Korell, M.D.  |                              |                  | Assistant  |                |                  | 11/27/80  |          |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |                              |                  | ADDRESS  |                |                  | 111 Penn Street, Balto., MD 21201   |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |                              |                  | 23b. DATE  |                |                  | 23c. NAME OF CEMETERY OR CREMATORY  |          |  |
| Burial   |                              |                  | 11-29-80   |                |                  | Dulaney Valley Cem.   |          |  |
| 24. FUNERAL DIRECTOR   |                              |                  | 25a. DATE REC'D. BY REGISTRAR  |                |                  | 25b. REGISTRAR'S SIGNATURE  |          |  |
| John C. Miller Inc-6415 Belair Rd.-21206   |                              |                  | DEC 1 1980   |                |                  | R. J. Brady   |          |  |

BP



**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

FOR  
1- REGISTRAR

|  |         |  |                   |  |      |   |      |   |  |  |  |
|--|---------|--|-------------------|--|------|---|------|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         |  |                   | 2a. DATE KNOWN OF DEATH  |      |   |      | 2b. HOUR  |  |  |  |
| Harold DeShield  |         |  |                   | <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR<br>11 16 1980 |      |   |      | 2b. HOUR<br>8:14 a.m.   |  |  |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   | 6. AGE (IN YEARS) | IF UNDER 1 YR.   |      | IF UNDER 24 HRS.  |      | 7c. DATE PRONOUNCED DEAD  |  | 2d. HOUR                                     |  |
| Male   | Black   | 12 28 23   | 56 YRS.           | MONTHS   | DAYS | HOURS   | MIN. | 11 16 1980  |  | 8:14 a.m.                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?                             |                   | 8. MARRIED   |      | 9. BALTIMORE CITY OR COUNTY OF DEATH                      |      |   |  |  |  |
| Md.  |         | U.S.   |                   | <input type="checkbox"/> NEVER MARRIED<br><input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED       |      | Baltimore City  |      | MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |                   |  |      | 12a. USUAL OCCUPATION                                     |      | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |
| Baltimore  |         | 610 N. Monroe St., 2nd Floor                             |                   |  |      | (TYPE OF WORK FOR MOST OF WORKING LIFE)                   |      |   |  |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |         |  |                   |  |      |   |      |   |  |  |  |
| 13a. STATE   |         | 13b. COUNTY  |                   | 13c. CITY OR TOWN  |      | 13d. STREET ADDRESS                                       |      |   |  |  |  |
| Md.  |         |  |                   | Balto.   |      | 610 N. Monroe St.   |      |   |  |  |  |
| 14. FATHER'S NAME  |         |  |                   |  |      | 15. MOTHER'S MAIDEN NAME                                  |      |   |  |  |  |
| Leon DeShield  |         |  |                   |  |      | Annie Culleney  |      |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |         |  |                   | 16b. SOCIAL SECURITY NO.   |      | 17. INFORMANT   |      |   |  |  |  |
| no   |         |  |                   | 212-12-6975  |      | Eva Williams 4776 Monnie Brae Rd. Balto. Md. 21208 Sister |      |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |  |                   |  |      |   |      |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b><br>4029 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. }<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |         |  |                   |  |      |   |      |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I   |         |  |                   |  |      |   |      |   |  |  |  |
| 19a. DATE OF OPERATION   |         |  |                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |      |   |      | 20. AUTOPSY?  |  |  |  |
|  |         |  |                   |  |      |   |      | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         |  |                   | 21b. TIME OF INJURY  |      | 21c. HOW INJURY OCCURRED                                  |      |   |  |  |  |
|  |         |  |                   | HOUR A.M. MONTH DAY YEAR   |      | ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2        |      |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |         |  |                   | 21e. PLACE OF INJURY   |      | 21f. LOCATION   |      |   |  |  |  |
|  |         |  |                   | (AT HOME, STREET, FACTORY, FARM, ETC.)   |      | CITY OR TOWN COUNTY STATE                                 |      |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |  |                   |  |      |   |      |   |  |  |  |
| ACTUAL SIGNATURE   |         |  |                   | TITLE (SPECIFY)  |      |   |      | DATE SIGNED   |  |  |  |
| <i>Margarita A. Korell</i>   |         |  |                   | Assistant  |      |   |      | 11-16-80  |  |  |  |
| EXAMINER'S NAME  |         |  |                   | ADDRESS  |      |   |      |   |  |  |  |
| (TYPE OR PRINT) Margarita A. Korell, M.D.  |         |  |                   | 111 Penn Street  |      |   |      |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL  |         | 23b. DATE  |                   | 23c. NAME OF CEMETERY OR CREMATORY   |      | 23d. LOCATION   |      | 23e. DATE REC'D. BY REGISTRAR                                       |  |  |  |
| (SPECIFY) Burial   |         | 11/21/80   |                   | Arbutus Mem. Park  |      | Balto. Md.  |      | NOV 17 1980   |  |  |  |
| 24. FUNERAL DIRECTOR   |         |  |                   | 25a. DATE REC'D. BY REGISTRAR  |      |   |      | 25b. REGISTRAR'S SIGNATURE  |  |  |  |
| C. Wainwright 2700 Edmondson Ave.  |         |  |                   |  |      |   |      | <i>[Signature]</i>  |  |  |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING TO THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 7 9 8 0

REG. NO.

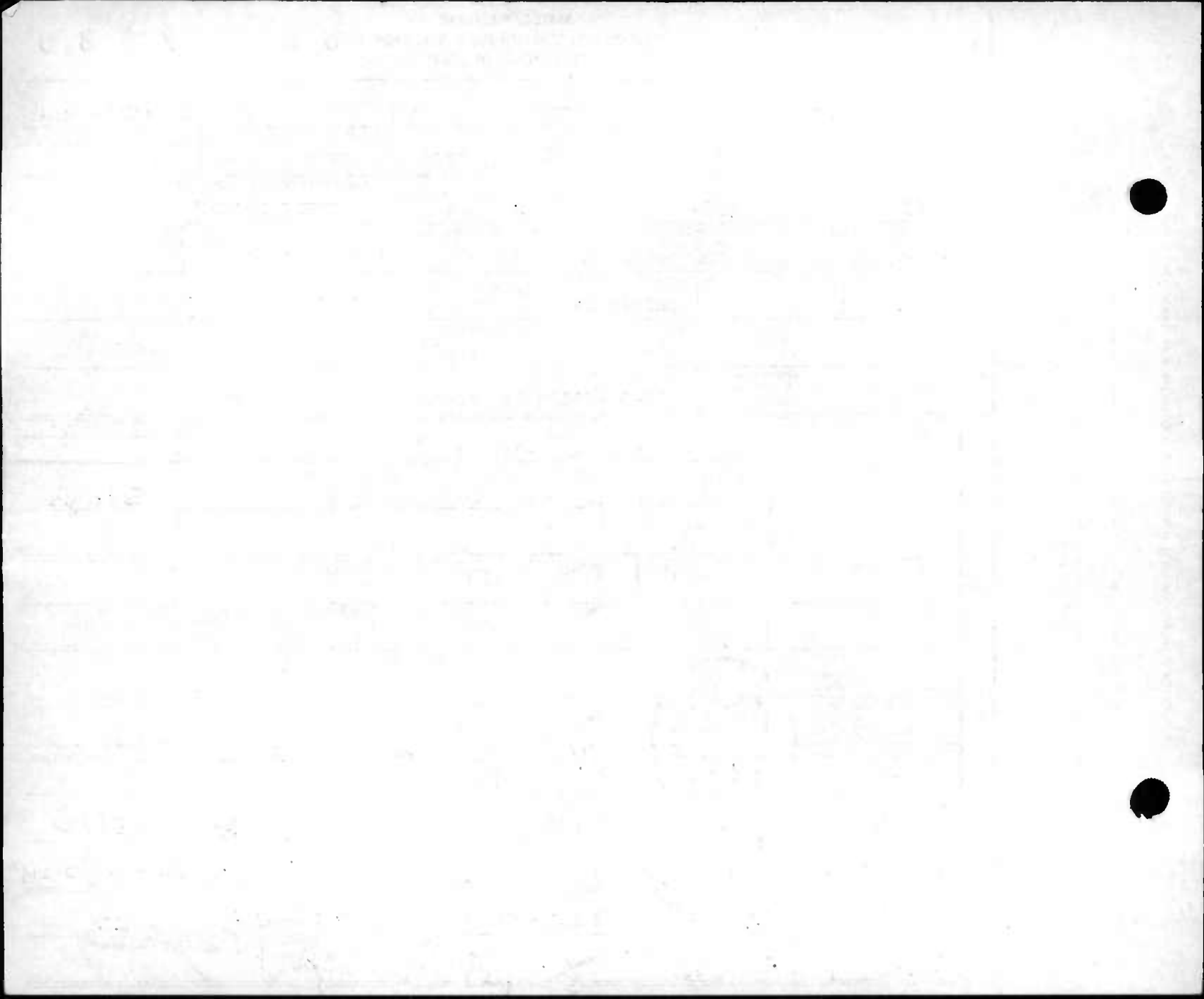
1. FOR  
STATE  
REGISTRAR

|   |  |   |   |  |                             |  |  |
|---|--|---|---|--|-----------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>LUZMIRA DIAZ (Soto)</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 5 80</b> |  | 2b. HOUR<br><b>11:03 AM</b> |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept 24, 1912</b>   |                             | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>68</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Chile</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>Chile</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |                             | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b> |   |  |                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Home Maker</b>                                      |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>  |                             | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Pedro Soto</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Cecelia Espindola</b>   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |                             | 16b. SOCIAL SECURITY NO.<br><b>123-34-0112</b>   |  |
| 17. INFORMANT<br><b>Mr Marcos Diaz</b>  |  | ADDRESS<br><b>Same</b>  |   | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br><b>430-</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>SUBARACHNOID HEMORRHAGE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Rupture of Aneurysm.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                             |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |  |                             |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                             | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                             |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                             |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/1</b> , 19 <b>80</b> , to <b>11/5</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>11/5</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. |  |   |   |  |                             |  |  |
| 22b. SIGNATURE<br><b>Robert S. Schupp</b>   |  | DEGREE<br><b>MD</b>   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>   |                             | 22c. DATE SIGNED<br><b>11/5/80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ROBERT SCHUPP MD</b>  |  | 22e. ADDRESS<br><b>UNION MEMORIAL HOSPITAL BAL MD 21218</b>   |   |  |                             |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11/10/80</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Caleta-Abarca</b>   |                             | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Valparaiso Chile</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J. Ruck</b>  |  | ADDRESS<br><b>Baltimore, Maryland</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 6 1980</b>   |                             | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |  |   | REG. NO.   |  |
|---|--|---|--|---|--|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>WILLIAM P. DICKERSON SR.   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 4 1980         |   |  |  |   | 2b. HOUR<br>9:32   |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 12 01  |  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>79 YRS.                                 |  |   | 7. UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                 |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BON SECOURS HOSPITAL |  |   |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>BREWER |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>BREWERY   |  |
| 13a. STATE<br>MARYLAND  |  | 13b. COUNTY<br>---  |  | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>230 STONECROFT ROAD APT. J                                    |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>PHILLIMAN DICKERSON   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>SOPHIA HICKEY |   |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO  |  |   |  | 16b. SOCIAL SECURITY NO.<br>218-01-9192   |  | 17. INFORMANT<br>ADDRESS<br>APT. H<br>WILLIAM P. DICKERSON, JR. 232 STONECROFT RD.              |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio-vascular Arrest.</u><br>1541<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cx of Renal &amp; Metabolism.</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____ |  |   |  |   |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost<br>saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) did not view the body after death.  |  |   |  |   |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><u>ABRAHAMSON</u>   |  |   |  |   |  | DEGREE<br>MD.   |  |  | 22c. DATE SIGNED<br>11/11/80  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>ABRAHAMSON</u>  |  |   |  |   |  | 22e. ADDRESS<br><u>Bon Secours Hosp.</u>  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  |   |  | 23b. DATE<br>11-04-80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>LOUDON PARK   |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE CITY MARYLAND |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>HUBBARD FUNERAL HOME, INC.  |  |   |  |   |  | ADDRESS<br>4107 WILKENS AVE.  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 3 1980  |   | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 7 9 8 2

REG. NO.

|   |  |   |   |  |                              |  |
|---|--|---|---|--|------------------------------|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <i>Eileen M. Dignazio</i>  |  |   | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><i>11/16/80</i> |  | 2b HOUR<br><i>12:55 A.M.</i> |  |
| 3 SEX<br><i>Female</i>  |  | 4 RACE<br><i>White</i>  |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><i>Apr. 1, 1931</i>   |                              |  |
| 6 AGE (IN YEARS (LAST BIRTHDAY))<br><i>49</i>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |   | IF UNDER 24 HRS<br>HOURS MIN.  |                              |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Baltimore, Md.</i>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>                                |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |                              |  |
| 9 BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City,</i>   |  | 10 CITY OR TOWN OF DEATH<br><i>Baltimore</i>                                |   | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Baltimore City Hospital</i>   |                              |  |
| 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Laborer</i>   |  | 12b KIND OF BUSINESS OR INDUSTRY<br><i>Distillery</i>                       |   | 13a STATE<br><i>Md.</i>  |                              |  |
| 13b COUNTY<br><i>---</i>  |  | 13c CITY OR TOWN<br><i>Baltimore</i>  |   | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                              |  |
| 14 FATHER'S NAME<br><i>John F. Rankin, Sr.</i>  |  | 15 MOTHER'S MAIDEN NAME<br><i>Bertha C. Brandt</i>                          |   | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>   |                              |  |
| 16b SOCIAL SECURITY NO.<br><i>---</i>   |  | 17 INFORMANT<br><i>1104 Steelton Ave. - Balto.,</i>                         |   | 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>cardiopulmonary arrest</i><br>4360 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <i>thrombophlebitis CVA</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>---</i> |                              |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><i>sp mti x2</i>                                  |  |   |   |  |                              |  |
| 19a DATE OF OPERATION<br><i>11/8/80</i>   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>---</i>               |   | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                              |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                 |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>---</i> P.M. <i>19</i> |   | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                              |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)       |   | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                              |  |
| 22a I certify that (I) (this hospital) attended the deceased from <i>11/8/80</i> to <i>11/16/80</i> that (I) (we) lost <i>above</i> , (I) (we) did (did not) view the body after death. |  |   |   |  |                              |  |
| 22b SIGNATURE<br><i>N. Cutler M.D.</i>  |  | DEGREE  |   | 22c DATE SIGNED<br><i>11/16/80</i>   |                              |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>N. CUTLER</i>  |  | 22e ADDRESS<br><i>Baltimore City Hospital</i>                               |   |  |                              |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>  |  | 23b DATE<br><i>11/19/80</i>   |   | 23c NAME OF CEMETERY OR CREMATORY<br><i>Sacred Heart of Jesus-Baltimore, Md.</i>   |                              |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><i>John A. Moran, Inc.</i>   |  | 25 DATE REC'D. BY REGISTRAR<br><i>NOV 19 1980</i>                           |   | 26 REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |                              |  |

MEDICAL CERTIFICATION

2  
9

1

M

35

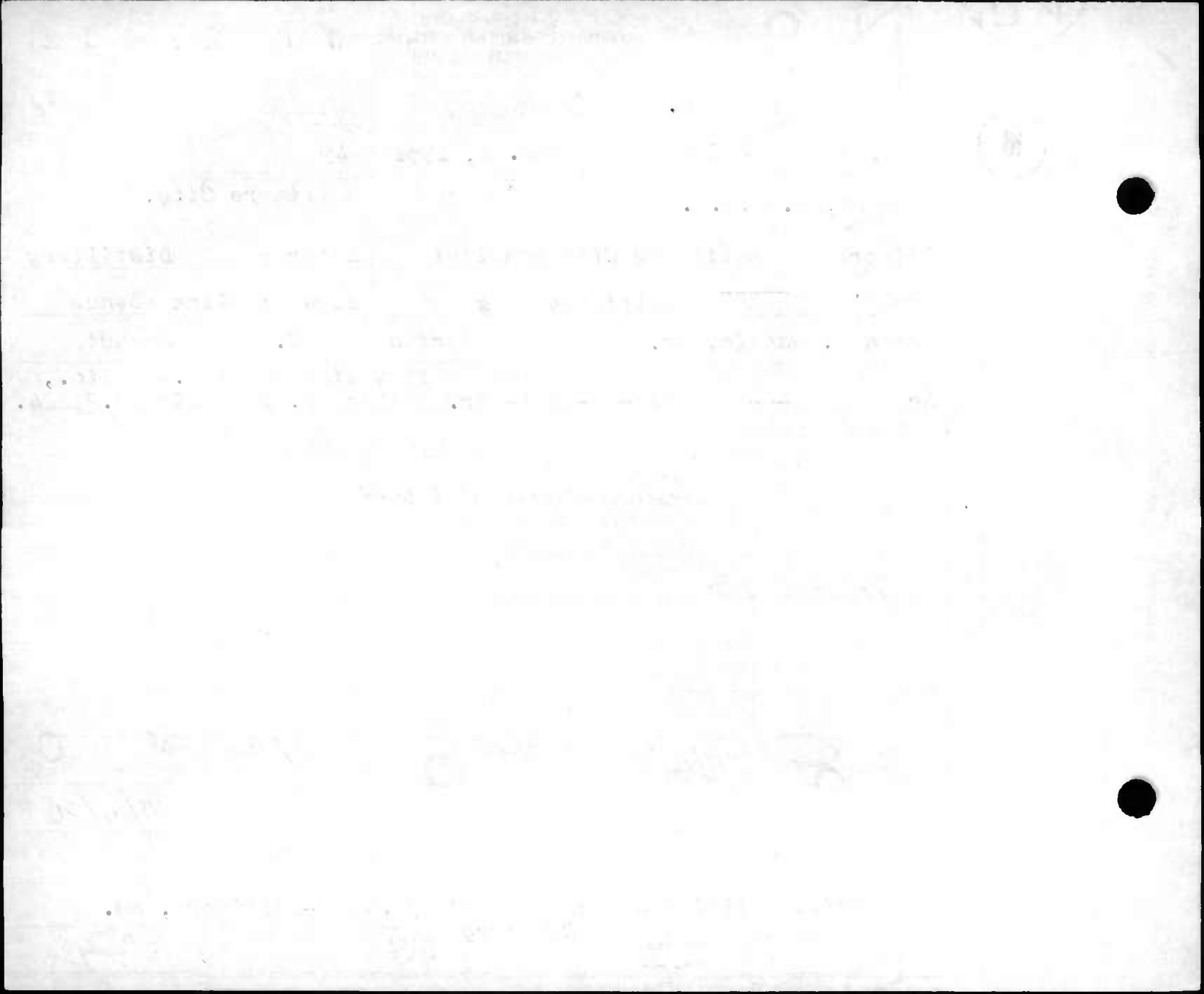
31

35

300

1

2636 BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8 0 2 7 9 8 3  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  | REG. NO.   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Guido Anthony Dimuzio</b>  |  |  |  | 2a. DATE OF DEATH MONTH <b>11</b> DAY <b>29</b> YEAR <b>1980</b>   |  | 2b. HOUR <b>12:40</b> M <b>40</b>   |  |
| 3. SEX <b>Male</b>   |  | 4. RACE <b>White</b>   |  | 5. DATE OF BIRTH MONTH <b>2</b> DAY <b>17</b> YEAR <b>96</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Italy</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. AGNES HOSPITAL</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Tailor</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>  |  |
| 13a. STATE <b>Md</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Catonsville</b>   |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS <b>423 Neepier Road</b>   |  |
| 14. FATHER'S NAME FIRST <b>Louis</b> MIDDLE <b>DiMuzio</b> LAST <b>DiMuzio</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Anita</b> MIDDLE <b>(Unknown)</b> LAST <b>(Unknown)</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>215-07-5176</b>  |  | 17. INFORMANT ADDRESS <b>Helen DiMuzio Same as #13</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory failure.</b><br><b>4140</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Pneumonia.</b><br>(c) <b>Arterio Sclerotic heart disease.</b>  |  |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that <del>the</del> (this hospital) attended the deceased from <b>Nov 28, 1980</b> to <b>Nov 29, 1980</b> , that <del>we</del> (we) lost <del>saw</del> the deceased alive on <b>Nov 29, 1980</b> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>we</del> (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE <b>T.P. Reddy</b> DEGREE <b>DR. T.P. REDDY</b>  |  |  |  | 22c. DATE SIGNED <b>Nov 29, 1980</b>   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Graham</b>   |  |
| 22e. ADDRESS <b>ST. AGNES HOSPITAL, BALTIMORE, MD, 21229</b>   |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Entombment</b>  |  | 23b. DATE <b>12/2/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Crestlawn Mausoleum</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Marriottsville Howard Maryland</b>   |  |
| 24. FUNERAL DIRECTOR NAME <b>Witzke Funeral Home of Catonsville</b> ADDRESS <b>1630 Edmondson Avenue Catonsville, Md. 21228</b>  |  |  |  | 25a. DATE REC'D BY REGISTRAR <b>DEC 2 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Barry A. Brady</b>  |  |

BP

CHICAGO CITY

CHICAGO CITY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 7 9 8 4

REG. NO.

|  |  |  |  |   |                              |  |   |  |  |
|--|--|--|--|---|------------------------------|--|---|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Elsie Cordelia Disney   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 19, 1980             |   |                              | 2b. HOUR<br>7:55 PM  |   |  |  |
| 3 SEX<br>Female  |  | 4 RACE<br>Caucasian  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Apr. 11, 1901   |                              | 6. AGE (IN YEARS LAST BIRTHDAY)<br>79 YRS  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>South Baltimore Gen. Hospital |  |   |                              | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                              |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br>Maryland  |  |  | 13b. COUNTY<br>Baltimore   |   | 13c. CITY OR TOWN<br>Arbutus |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Harvey L. Meese  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Minnie E. Heinbaugh |   |                              | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No N/A |   |  |  |
| 16b. SOCIAL SECURITY NO.<br>221-16-8434  |  |  | 17. INFORMANT<br>ADDRESS<br>Mrs. Jeanne M. Mezger Same as # 13       |   |                              |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u><br>4151<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>PULMONARY EMBOLISM</u><br>(c) <u>BILATERAL DEEP VEIN THROMBOSIS</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><u>PARAPLEGIA (TRAUMATIC) 15 YRS.; ISCHEMIC HEART DISEASE, MULTIPLE MYELOMA.</u> |  |  |  |   |                              |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |                              | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                              |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                              |  |   |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>10/23/1980</u> to <u>11/19/1980</u> , that (1) <del>was</del> last saw the deceased alive on <u>11/19/1980</u> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (1) <del>was</del> (did) <del>not</del> view the body after death.  |  |  |  |   |                              |  |   |  |  |
| 22b. SIGNATURE<br><u>R. Dharma Sena</u>  |  |  |  | DEGREE<br>M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |                              |  |   | 22c. DATE SIGNED<br>11/20/80   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>K. DHARMA SENA  |  |  |  | 22e. ADDRESS<br>8 16th Av.W. Brooklyn Park, Md. 21225   |                              |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>11/22/80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park   |                              | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore City, Maryland                                     |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>MacNabb Funeral Home   |  |  |  | ADDRESS<br>Catonsville, Md.   |                              | 25a. DATE REC'D. BY REGISTRAR<br>NOV 20 1980   |   | 25b. REGISTRAR'S SIGNATURE<br><u>R. Dharma Sena</u>  |  |

BP

DHMH-16 25M  
(VRA 15, 4) 1/79

U.S. G. A.



*Handwritten signature or initials.*

U.S. G. A.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |   |  |
|--|--|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>ELIZABETH Wainwright DITTRICH   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 21/80        |   |  | 2b. HOUR<br>6:20 A.M.  |  |   |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>MAY 1, 1906   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>own home                   |  |
| 13a. STATE<br>Maryland   |  |  | 13b. CITY<br>City  |   | 13c. CITY OR TOWN<br>Brooklyn  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Richardson   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Agnes Swank |   |  | 13e. STREET ADDRESS<br>1312 Tompkins Street  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>N/A   |  | 17. INFORMANT<br>(Son) ADDRESS<br>same as 13  |  | Mr. Kenneth M. Dittrich  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Sepsis</u><br>0389<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.               |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>Stroke</u>  |  |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7/16</u> , 19 <u>80</u> , to <u>11/21</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>11/21</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br>David M. Fishbein M.D.   |  |  |  | DEGREE<br>M.D.  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>11/21/80                                    |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DAVID M. FISHBEIN, M.D.   |  |  |  | 22e. ADDRESS<br>UNION MEMORIAL HOSPITAL   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>Nov. 24, 1980   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cem.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Brooklyn A. MD.  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Singleton Funeral Home   |  |  |  | ADDRESS<br>Glen Burnie Md.  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 25 1980   |  | 25b. SIGNATURE<br>P. J. Kelly                                   |  |

TO : DIRECTOR, FBI (100-388610)

FROM : SAC, NEW YORK (100-100000)

SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

CLASSIFICATION: [Illegible]

100-100000

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Physicians are retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |                             |  |
|---|--|--|--|---|-----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>MARY. JANE Divers.</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11-23-80</b> |   | 2b. HOUR<br><b>8 30P.M.</b> |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>FEB. 25, 1892</b>  |                             |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>88</b> YRS.   |  | 7. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                             |  |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Provident Hospital</b>                      |                             |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>School Teacher</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Education</b>  |  | 13. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |                             |  |
| 14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>14a. STATE<br><b>Maryland</b>  |  | 14b. COUNTY<br><b>Harford Co.</b>  |  | 14c. CITY OR TOWN<br><b>Joppa</b>   |                             |  |
| 15. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Thomas Dalton</b>   |  | 16. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Viola Shaum</b>  |  | 17. STREET ADDRESS<br><b>700 Whitaker Mill Road</b>   |                             |  |
| 18a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 18b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>212-70-5364</b>  |  | 19. INFORMANT (Name) <b>Alan Getz</b> ADDRESS<br><b>26 South Main Street<br/>Belt Air, Maryland 21014</b>   |                             |  |
| 20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST:</b><br>2765<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>DEHYDRATION, ASCVD.</b><br>Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |                             |  |
| 21a. DATE OF OPERATION  |  | 21b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 21c. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                             |  |
| 21d. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21e. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21f. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)  |                             |  |
| 21g. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21h. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21i. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                             |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |                             |  |
| 22b. SIGNATURE<br><b>Gaspar Del Monte</b>   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>Nov. 23, 1980</b>  |                             |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>GASPAR Del Monte, M.D.</b>  |  | 22e. ADDRESS<br><b>Provident Hospital 2600 Liberty Hgts</b>  |  |   |                             |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Nov. 26, 1980</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. John Cath. Ch. Cem.</b>  |                             |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Long Green, Balto. Co., Maryland</b>   |  | 24. FUNERAL DIRECTOR<br><b>Joseph William Foster</b><br>W. Broadway & Williams St.<br>Belt Air, Maryland 21014                                       |  |   |                             |  |
| 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 20 1980</b>   |  | 25b. SIGNATURE<br><b>John H. H. H.</b>   |  |   |                             |  |

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 7 9 8 7

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |   |  |   |                        |   |  |  |  |  |  |
|--|--|---|--|---|------------------------|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ROBERT L. DODSON</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 27 80</b> |   | 2b. HOUR<br><b>A M</b> |   |  |  |  |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>01 19 06</b>   |                        | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YEARS MONTHS DAYS<br><b>74 YRS</b>                           |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>0 0 0</b>  |  | 8. IF UNDER 24 HRS<br>HOURS MIN.<br><b>0 0</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VIRGINIA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                        | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>4215 ELDONE ROAD, 21229</b> |  |   |                        | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>PAINTER</b>              |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>DECORATING</b>   |  |  |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>---</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |                        | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>4215 ELDONE ROAD, 21229</b>  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>MARVIN DODSON</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>JULIA HAYNIE</b>  |  |   |                        |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>214-03-6510</b>   |  | 17. INFORMANT ADDRESS<br><b>KENNETH, DODSON 4215 ELDONE ROAD, 21229</b>   |                        |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br><b>1629</b> IMMEDIATE CAUSE (a) <b>Respiratory Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>lung cancer</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>6 mos.</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 wks</b>   |  |   |  |   |                        |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |                        |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |                        | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                        |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                        |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/17</b> 19 <b>80</b> to <b>10/9</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>10/9</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |   |                        |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>William Waterfield</b>  |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |                        |   |  | 22c. DATE SIGNED<br><b>11/28/80</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>WILLIAM WATERFIELD, M.D.</b>   |  |   |  | 22e. ADDRESS<br><b>ST. AGNES HOSPITAL, 900 S. CATON AVENUE</b>  |                        |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>11-29-80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MEADOWRIDGE MEM. PK.</b>   |                        | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ELKRIDGE HOWARD MARYLAND</b>                   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. 21229</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 28 1980</b>   |                        | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |  |  |  |  |

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U.S. DEPARTMENT OF JUSTICE



0001 8SV04

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 2 7 9 8 8  
CERTIFICATE OF DEATH

|   |  |   |  |
|---|--|---|--|
| FOR<br>1- STATE<br>REGISTRAR  |  | REG. NO.  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>JOHN C DOETSCH, SR.  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11-3-80<br>2b. HOUR<br>3:45 AM   |  |
| 3. SEX<br>Male  | 4. RACE<br>Caucasian   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Jan. 6, 1919  |  |
| 6a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD. |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Plastic Co.  |  |
| 13b. COUNTY<br>-  |  | 13c. CITY OR TOWN<br>Baltimore  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Ernst Doetsch   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elizabeth Cottle   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>218-10-8761   |  |
| 17. INFORMANT<br>Catherine R. Doetsch, wife, same   |  | ADDRESS<br>address  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>M40 INFARCTION</u><br><u>4100</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>COR. ART DIS</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 hr.</u><br><u>10 yrs.</u> |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>19 77</u> to <u>Nov 3</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>Nov 3</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |
| 22b. SIGNATURE<br><u>[Signature]</u>  |  | 22c. DATE SIGNED<br><u>10/11/80</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>M D KELSMAN</u>   |  | 22e. ADDRESS<br><u>UNION MEM HOSP.</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>11/6/80  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Most Holy Redeemer  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md.   |  |
| 24. FUNERAL DIRECTOR<br>Schamunek Funeral Home, Inc.  |  | 24b. ADDRESS<br>3331 Brehms Lane Balto., Md. 21213  |  |



*[Faint, mostly illegible handwritten text and markings covering the majority of the page. Some words like "TO", "FROM", and "SUBJECT" are faintly visible.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

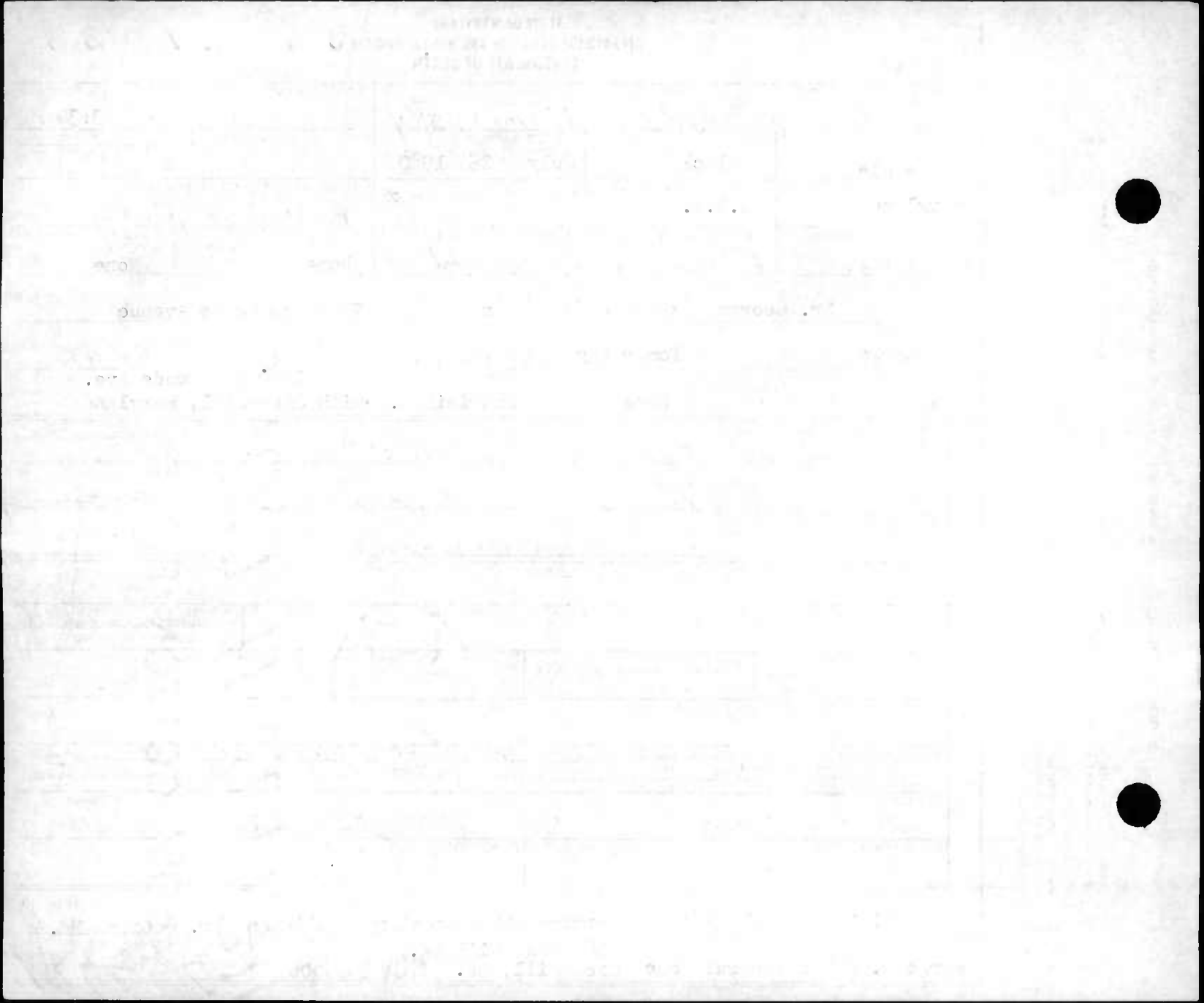
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 27989

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |   |  |   |
|---|---|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Patricia Andrea Domarasky</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11/11/80</b>  |  | 2b. HOUR<br><b>3:30 P.M.</b>  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>Black</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 25 1980</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS MONTHS DAYS<br><b>3 16</b>                    |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore, City MD.</b>                   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore City Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>None</b>                 |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>                                  |
| 13a. STATE<br><b>Maryland</b>   |   | 13b. CITY OR TOWN<br><b>Pr. George</b>  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET ADDRESS<br><b>7909 Den Meade Avenue</b>                                  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George Domarasky</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Patricia A. Smith</b>   |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>None</b>   |   | 17. INFORMANT<br><b>Patricia A. Smith Oxon Hill, Maryland</b>                        |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b><br><b>7483</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Bronchopulmonary Dysplasia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Respiratory Distress syndrome</b>        |   |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>2 mths</b><br><b>3 mths</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |   |   |   |  |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>July 25 1980</b> to <b>November 11 1980</b> , that (I) (we) last saw the deceased alive on <b>Nov. 11 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. |   |   |   |  |   |
| 22b. SIGNATURE<br><b>Alex Ray</b>   |   | DEGREE<br><b>M.D.</b>   |   | 22c. DATE SIGNED<br><b>11/11/80</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ALEX RAY</b>  |   | 22e. ADDRESS<br><b>Dept. of Pediatrics<br/>Baltimore City Hospital</b>  |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |   | 23b. DATE<br><b>11/14/80</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Resurrection Cemetery</b>                   |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Clinton Pr. George Md.</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 18 1980</b>   |   |  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>George P. Kalas Funeral Home</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Patricia A. Smith</b>  |   |  |   |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                  |  |   |  |  |  |  |  | REG. NO. 60 27990  |  |  |  |
|---|--|------------------|--|---|--|--|--|--|--|--|--|--|--|
| 1- FOR STATE REGISTRAR  |  |                  |  |   |  |  |  |  |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Fredie Donaldson  |  |                  |  |   |  |  |  |  |  | 2b. DATE KNOWN OF DEATH ESTI MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 11 9 19 80 |  |  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Black |  | 5. DATE OF BIRTH MONTH DAY YEAR 1 23 23   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.                      |  | IF UNDER 1 YR. MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.  |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.   |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                                      |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1010 W. Fayette Street |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN<br>Md. Balto.   |  |                  |  |   |  |  |  |  |  | 13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>     |  |  |  |
| 13c. STREET ADDRESS<br>1010 W. Fayette St.  |  |                  |  |   |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>James Donaldson  |  |                  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Addie Streeter |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no   |  |                  |  |   |  | 16b. SOCIAL SECURITY NO.                                     |  |  |  |  |  |  |  |
| 17. INFORMANT ADDRESS<br>Herbert Donaldson 4804 ParkHeight  |  |                  |  |   |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>4292 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) }<br>(c) } DUE TO, OR AS A CONSEQUENCE OF  |  |                  |  |   |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |                  |  |   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                 |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                  |  |   |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE  |  |                  |  | TITLE (SPECIFY)<br>Deputy Chief   |  |  |  | DATE SIGNED 11/10/80   |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Thomas D. Smith, M.D.  |  |                  |  | ADDRESS<br>111 Penn St. Balto., MD.   |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |                  |  | 23b. DATE<br>11/17/80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Zion               |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Balto. Md.  |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>C. Wainwright  |  |                  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 17 1980                 |  |  |  |  |  |  |  |
| ADDRESS<br>Funeral Home 2700 Edmond   |  |                  |  |   |  | 25b. REGISTRAR SIGNATURE                                     |  |  |  |  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |   | 8 0 2 7 9 9 1  |   |
|--|--|---|---|--|---|
| 1 - FOR STATE REGISTRAR  |  |   |   | CERTIFICATE OF DEATH   |   |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |   |   | 2a. DATE OF DEATH  |   |
| FIRST MIDDLE LAST  |  |   |   | MONTH DAY YEAR   | 2b. HOUR  |
| DORIS DONATT   |  |   |   | Nov 10 80  | 11 05 AM  |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH  |   | 6. AGE (IN YEARS LAST BIRTHDAY)  |   |
| Female   | CAU.   | MONTH DAY YEAR<br>9 8 12  |   | 68 YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                     |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH   |   |
| Maryland   | U S A  |   |   | BALTIMORE CITY MD.   |   |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  | 12b. KIND OF BUSINESS OR INDUSTRY   |
| BALTIMORE  | JOHNS HOPKINS HOSP.  |   | HOUSE WIFE  |  |   |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |   |  |   |
| 13a. STATE   | 13b. COUNTY  | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS  |   |
| Maryland   |  | Baltimore   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 103 Upmanor Road 21229   |   |
| 14. FATHER'S NAME  |  |   | 15. MOTHER'S MAIDEN NAME  |  |   |
| FIRST MIDDLE LAST<br>Charles Adam Weinreich  |  |   | FIRST MIDDLE LAST<br>Bertha A. Smith                                |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT ADDRESS  |   |
| no   |  | 215-09-86038  |   | Howard J. Donatt, 103 Upmanor Road 21229                                       |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Undifferentiated Metastatic Carcinoma</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>unknown source, possible Breast</u>                                  |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>2 months.</u><br><u>14 years</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1  |  |   |   |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?                      |
|  |  |   |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | YES <input type="checkbox"/> NO <input type="checkbox"/>                            |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>June 11/9</u> 19 <u>80</u> , to <u>11/10</u> 19 <u>80</u> , that (1) (we) lost saw the deceased alive on <u>11/9</u> 19 <u>80</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did not) view the body after death. |  | 22b. SIGNATURE<br><u>Anne L. Leddy MD</u>   |   | 22c. DATE SIGNED<br><u>11/10/80</u>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS  |   |  |   |
| ANNE L. LEDDY MD   |  | 9 E. CHASE ST BALTIMORE MD 21202  |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE   | 23c. NAME OF CEMETERY OR CREMATORY                                  | 23d. LOCATION  |   |
| Burial   |  | 11/13/80  | Oaklawn Cemetery  | BALTIMORE, Maryland  |   |
| 24. FUNERAL DIRECTOR 1630 Edmondson Avenue, Catonsville, Md  |  |   |   |  |   |
| NAME   |  | ADDRESS   |   | DATE REC'D. BY REGISTRAR   |   |
| Witzke Funeral Home of Catonsville, P.A.   |  | 21228   |   | NOV 13 1980  |   |
| 25. REGISTRAR'S SIGNATURE<br><u>Barbara M. Leddy</u>   |  |   |   |  |   |

---

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 7 9 9 2

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Isabel M. Donohue  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 10 1980  |   | 2b. HOUR<br>M  |
| 3 SEX<br>Female  | 4 RACE<br>White  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>Nov 13 1903   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>76 YRS.                                 | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                 |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Union Memorial Hospital |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   |  |
| 13a. STATE<br>Md.  | 13b. COUNTY  | 13c. CITY OR TOWN<br>Baltimore   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  | 13e. STREET ADDRESS<br>413 E. Belvedere Ave                               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John A. McFadden   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Jane McHale  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>217-30-2688 A   | 17 INFORMANT<br>ADDRESS<br>Mary Patricia Donohue Same  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Hypertension</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Atherosclerotic Cardiovascular Disease</u><br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>June 26</u> 19 <u>78</u> to <u>Sept 29</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>Sept 1</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.  |  |  |  |   |  |
| 27b. SIGNATURE<br><u>George E. L. Long</u>   |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 27c. DATE SIGNED<br>11/14/80   |
| 27d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  | 27e. ADDRESS   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  | 23b. DATE<br>11/14/1980  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood Cemetery  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md                |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Mitchell-Wiedefeld Home  |  |  | ADDRESS<br>6500 York Rd.   |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 17 1980   |
|  |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>L. J. McCreedy</u>  |   |  |





10

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

2 7 9 9 3

REG. NO.

|   |  |   |   |  |  |  |  |
|---|--|---|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Caleb Dorsey Dorsey</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>11 14 80</b> |  |  | 2b. HOUR<br><b>7:15 PM</b>   |  |
| 3. SEX<br><b>male</b>   |  | 4. RACE<br><b>white</b>   |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>4 15 04</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b> YRS.                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>City Baltimore City MD</b>                |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balt.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Lutheran Hosp</b> |   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>De-nist</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>13a State Md</b>   |  | 13b. COUNTY<br><b>Balt.</b>   |   | 13c. CITY OR TOWN<br><b>Balt.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>late Caleb Dorsey</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>late Anna Maria Marden</b>  |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>214 38 5529A</b>   |   | 17. INFORMANT ADDRESS<br><b>Mrs Ruth Dorsey 524 N. Charles St 21201</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b><br><b>1991</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Metastatic Cancer</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): |  |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>11/14</b> , 19 <b>80</b> , to <b>11/14</b> , 19 <b>80</b> , that (I) (we) lost<br>saw the deceased give on <b>11/14</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) did not view the body after death.   |  |   |   |  |  |  |  |
| 22b. SIGNATURE<br><b>E.T. Souweine</b>  |  |   |   | DEGREE<br><b>no</b>  |  | 22c. DATE SIGNED<br><b>11/14/80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>E.T. Souweine</b>   |  |   |   | 22e. ADDRESS<br><b>Lutheran Hosp</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>Nov 15, 1980</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Memorial Park</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Catonsville BALTO Md</b>            |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Harry H Witzke 4112 Columbia Rd Ellicott City</b>  |  |   |   | 25a. DATE REC'D BY REGISTRAR<br><b>NOV 17 1980</b>   |  | 25b. RECEIVED BY<br><b>Epiphany</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

100-100000

RECEIVED

Calder

Donner

U.S.A.

Belgium City

James Calder Donner

late Anna Maria Donner

214 30 1254 Mrs Ruth Donner 204 E. Charles St. 1801

Continued on page 100-100000

100-100000 100-100000 100-100000

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 7 9 9 4

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Ralph S. Dorsey</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11/19/80</b>  |  | 2b. HOUR<br><b>4:03 P.M.</b>   |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>Black</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct. 2, 1917</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b> YRS                               | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>1 17</b>   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>         |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.              |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Provident Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Track Foreman</b>        |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>B. &amp; O.R.R.</b>  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Baltimore</b>  |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Rodney Dorsey</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>G. Olia Sheppard</b>                        |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>705-12-2671</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Madeline Dorsey, Same As #13</b>                |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio-Respiratory Arrest</b><br><b>2866</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>DIC</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Hypovolemic Shock</b> |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Diabetes Mellitus</b>  |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/19</b> , 19 <b>80</b> , to <b>11/19</b> , 19 <b>80</b> , that (I) (we) lost<br>saw the deceased alive on <b>11/19</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death                            |  |   |   |  |  |
| 22b. SIGNATURE<br><b>O. S. Jonas</b>  |  | DEGREE<br><b>M.D.</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>11/19/80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>O. S. Jonas</b>   |  | 22e. ADDRESS<br><b>Provident Hosp 2600 Liberty Hts.</b>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11-22-1980</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Fairview</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Carroll, Md.</b>  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Charles W. Burrier, Jr., Sykesville, Md.</b>   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 24 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert McCreedy</b>   |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



511 9 201

7 7

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 84

11-25-79

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical technician must be notified of such.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

2 7 9 9 5

REG. NO.

|   |  |  |  |   |  |   |   |   |                                     |  |
|---|--|--|--|---|--|---|---|---|-------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>CHARLES E. DOTSON</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 27 80</b>                 |   |  | 2b. HOUR<br><b>1:11p M</b>  |   |   |                                     |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>BLACK</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 23 11</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |                                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balto. Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY, MD.</b>  |   |   |                                     |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VETERANS ADMINISTRATION MEDICAL CENTER</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |   | 12b. KIND OF BUSINESS OR INDUSTRY   |                                     |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>  |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |                                     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles Dotson</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Maude Perkins</b>  |   |  | 17. INFORMANT ADDRESS<br><b>VAMC Meidcal Records 3900 LOCH RAVEN BLVD</b>   |   |   |                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>218261291</b>   |  | 17. INFORMANT ADDRESS<br><b>VAMC Meidcal Records 3900 LOCH RAVEN BLVD</b>   |  |   |   |   |                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>0389</b> IMMEDIATE CAUSE (a) <b>cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>20 min</b><br><b>2 wks</b> |  |  |  |   |  |   |   | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |                                     |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>          |                                     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |   |   |                                     |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |   |   |                                     |  |
| 22a. I certify that (I) (this hospital) received the deceased from <b>OCTOBER 7 19 80</b> , to <b>NOVEMBER 27 19 80</b> , that (we) lost <b>XX</b> above, the deceased <b>XX</b> on <b>NOVEMBER 27 19 80</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I/we) (did) (did not) view the body after death.   |  |  |  |   |  |   |   |   |                                     |  |
| 22b. SIGNATURE<br><b>R. J. Friedman MD</b>  |  |  | DEGREE<br><b>MD.</b>   |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   | 22c. DATE SIGNED<br><b>11/28/80</b> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>R. J. Friedman, MD</b>  |  |  | 22e. ADDRESS<br><b>3900 LOCH RAVEN BLVD</b>                            |   |  |   |   |   |                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>12/2/80</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Park</b>                 |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b>                                 |   |                                     |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>C. Wainwright</b>  |  |  | ADDRESS<br><b>270 Edmondson Ave.</b>                                   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 1 1980</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |                                     |  |



11 17 1:11

09

11

13

15

17

MINNEAPOLIS CITY

U.S.A.

VERNON H. HARRINGTON (MILITARY SERVICE)

WILLIAM HARRINGTON

787 FULTON ROAD, MINNEAPOLIS

1

MINNEAPOLIS

WILLIAM HARRINGTON

WILLIAM HARRINGTON (MILITARY SERVICE)

MINNEAPOLIS

WILLIAM HARRINGTON

WILLIAM HARRINGTON

11

13

15

17

19

21

MINNEAPOLIS

WILLIAM HARRINGTON (MILITARY SERVICE)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified as soon as possible.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |   |   |  |   |  | 80 27996  |  |
|---|--|---|--|---|---|---|--|---|--|---|--|
| 1- FOR STATE REGISTRAR  |  | REG. NO.  |  |   |   |   |  |   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>WILLIAM M DOWNING  |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>NOV 14 1980                                |   |  | 2b. HOUR<br>5:45 PM   |  |   |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>NEGRO  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 05 1906  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VIRGINIA   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD                                       |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>JEWISH CONVALESCENT HOME |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>COPPER WORKER |   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |
| 13a. STATE<br>MARYLAND  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>BALTIMORE  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>2121 PENROSE AVE   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Lula Downing  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Maggie Woodridge                 |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>705-10-9170   |  | 17. INFORMANT<br>ADDRESS<br>Mildred Hardy 2121 Penrose St.  |   |   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) ASCVD<br>4292<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |   |  |   |   |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |   |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12 NOV 80, 19 to 14 NOV 19 80, that (I) (we) lost<br>saw the deceased alive on 14 NOV 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did not) view the body after death. |  |   |  |   |   |   |  |   |  |   |  |
| 22b. SIGNATURE<br>[Signature]<br>DEGREE<br>MD<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |   |  |   |   | 22c. DATE SIGNED<br>11-14-80  |  |   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ARTHUR M. WEBSON MD  |  |   |  |   |   | 22e. ADDRESS<br>3640 FORDS LANE 21215   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |   | 23b. DATE<br>11/18/80  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Md. Nat'l Mem. Pk.                          |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Laurel MD   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H 1101 E. North Ave.   |  |   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 19 1980  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |  |   |  |

MEDICAL CERTIFICATION

99

U.S. DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D.C.



RECEIVED

20% COTTON





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80  
(VRA 15, 4)

| 1. FOR STATE REGISTRAR  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  | 8 0 2 7 9 9 7  |  | REG. NO.  |  |
|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Mary A. Doyle</b>   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>November 8, 1980</b>  |  | 2b. HOUR MIN.<br><b>2:15am</b>  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>May 22, 1896</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN.<br><b>84</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b>   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Custodian</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>School # 84</b>   |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Henry Bush</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Unknown</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>219-22-9127</b>  |  |
| 17. INFORMANT ADDRESS<br><b>Mr. Edward Humphreys, 3718 5th. St. Balto. Md.</b>  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic Congestive heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic Obstructive pulmonary disease</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b><br><b>years</b><br><b>years</b>  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION<br><b>10/21/80</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Ventilator Tracheostomy - Management</b>  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) <del>did not</del> <b>did</b> attend the deceased from <b>11/7</b> , 19 <b>80</b> , to <b>11/8</b> , 19 <b>80</b> , that (I) <del>was</del> <b>was</b> lost saw the deceased alive on above (I) <del>did not</del> <b>did</b> view the body after death. 19 <b>80</b> , and that in (my) <del>own</del> <b>own</b> opinion death occurred on the date and hour and from the causes stated |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Robert E. Roby, M.D.</b>   |  | DEGREE<br><b>M.D.</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22f. DATE SIGNED<br><b>11/8/80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ROBERT E. ROBY, M.D.</b>  |  | 22e. ADDRESS<br><b>8872 BELAIR RD. 21236</b>   |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Nov. 11, 1980</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Cross Cemetery</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>   |  | 24. FUNERAL DIRECTOR<br><b>McCutty Funeral Home, 130 E. Fort Ave. Balto. Md.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 12 1980</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Robert E. Roby</b>   |  |  |  |  |  |   |  |

MEDICAL CERTIFICATION

BP 2

THE CHURCH OF  
THE LIVING GOD  
1911

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_

STATE \_\_\_\_\_

COUNTRY \_\_\_\_\_

DATE \_\_\_\_\_

TIME \_\_\_\_\_

PLACE \_\_\_\_\_

BY \_\_\_\_\_

FOR \_\_\_\_\_

TO \_\_\_\_\_

FROM \_\_\_\_\_

THROUGH \_\_\_\_\_

AT \_\_\_\_\_

ON \_\_\_\_\_

OF \_\_\_\_\_

IN \_\_\_\_\_

BY \_\_\_\_\_

FOR \_\_\_\_\_

TO \_\_\_\_\_

FROM \_\_\_\_\_

THROUGH \_\_\_\_\_

AT \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

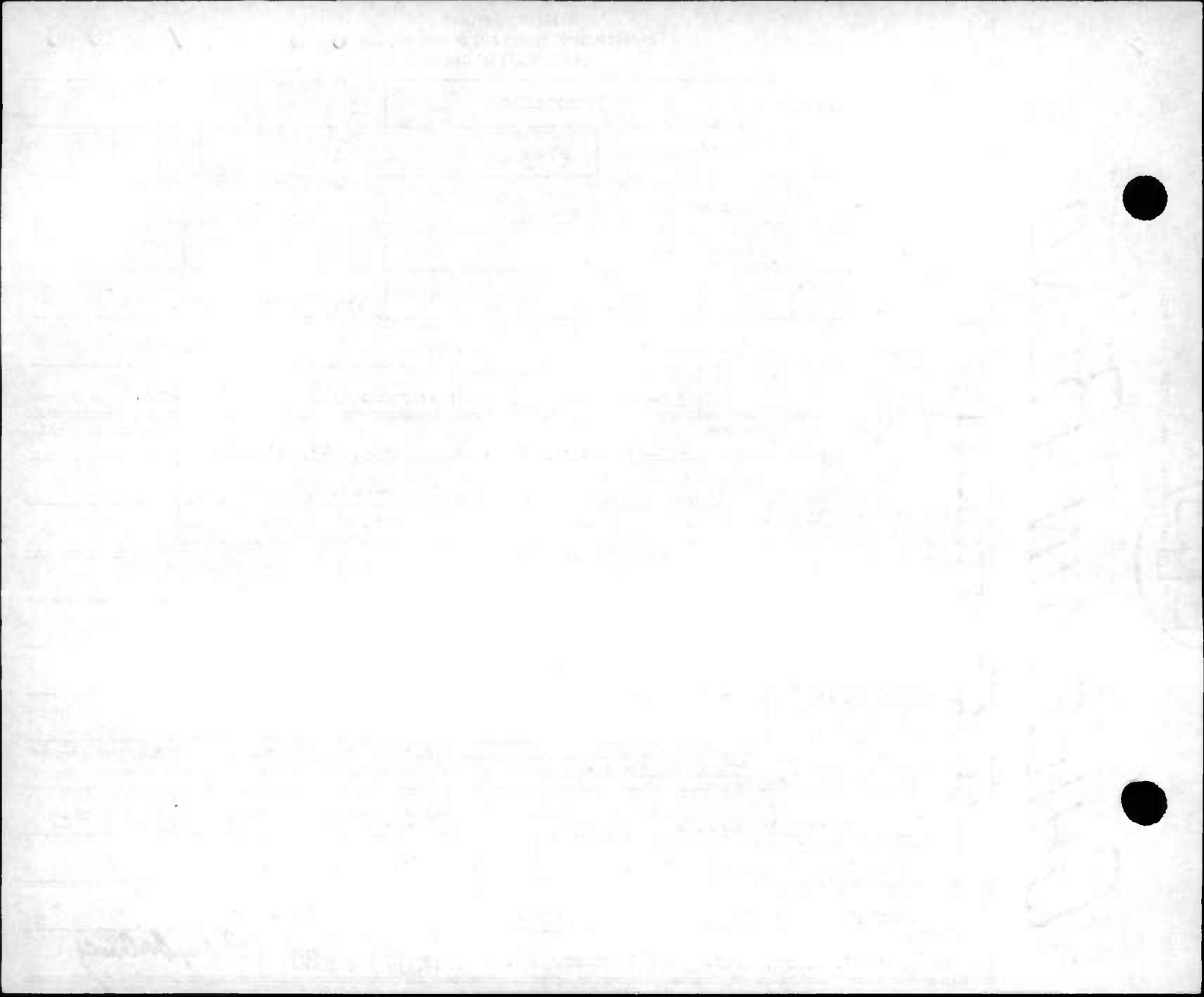
8 0

2 7 9 9 8

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |  |   |   |  |
|---|--|---|--|---|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Antanina Draugelis</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11-16-80</b> |   | 2b. HOUR<br>M<br><b>AM</b>   |   |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6-25-94</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS HOURS MIN.<br><b>86</b>   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Lithuania</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>Lithuania</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b> MD.  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3106 Chesley Ave.</b> |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY               |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   |  |   |   |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |   |  |
| 13e. STREET ADDRESS<br><b>3106 Chesley Ave.</b>   |  |   |  |   |  |   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Juozas Radzevicius</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Agota Unknown</b>   |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>212-60-3242</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Aleksas Raguckas, 3106 Chesley Ave.</b>  |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Sudden death - massive myo-</u><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>cardiac infarction. History of A.S.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Coronary artery disease. Advanced senility</u>   |  |   |  |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |  |   |  |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9.24</u> , 19 <u>80</u> , to <u>11.16</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>9.24</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |   |  |
| 22b. SIGNATURE<br><u>Stanley Ankudas M.D.</u>   |  | DEGREE<br><u>L</u>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br><u>11.17.80</u>   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Stanley Ankudas, M.D.</b>   |  | 22e. ADDRESS<br><b>1101 Maiden Choice La.</b>   |  |   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>11-19-80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b>   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J. Ruck, Inc., 5305 Harford Rd.</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 18 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |   |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

|  |         |                  |   |                |                  |   |  |  |   |  |  |
|--|---------|------------------|---|----------------|------------------|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         |                  | 2b. DATE KNOWN OF DEATH                                     |                |                  | 2c. DATE PRONOUNCED DEAD  |  |  | 2d. HOUR  |  |  |
| JOSEPH E. DREISCH  |         |                  | 11 20, 80   |                |                  | 11 20, 80   |  |  | 9:05 a.m.   |  |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS)   | IF UNDER 1 YR. | IF UNDER 24 HRS. | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                     |  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |  |
| male   | white   | 3 17 06          | 74 YRS.   |                |                  |   |  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH  |         |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION    |                |                  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |
| Baltimore  |         |                  | University Hospital   |                |                  |   |  |  |   |  |  |
| 13a. STATE   |         |                  | 13b. COUNTY   |                |                  | 13c. CITY OR TOWN   |  |  | 13d. STREET ADDRESS   |  |  |
| Md.  |         |                  | A.A.  |                |                  | Annapolis   |  |  | 1790-B Belle Drive  |  |  |
| 14. FATHER'S NAME  |         |                  | 15. MOTHER'S MAIDEN NAME                                    |                |                  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?                                  |  |  | 16b. SOCIAL SECURITY NO.  |  |  |
|  |         |                  |   |                |                  | Unkn.   |  |  | 216-18-6628   |  |  |
| 17. INFORMANT  |         |                  | ADDRESS   |                |                  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)     |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |  |
|  |         |                  |   |                |                  | PART I DEATH WAS CAUSED BY: Arteriosclerotic cardiovascular disease           |  |  |   |  |  |
|  |         |                  |   |                |                  | IMMEDIATE CAUSE (a) 4292  |  |  |   |  |  |
|  |         |                  |   |                |                  | DUE TO, OR AS A CONSEQUENCE OF  |  |  |   |  |  |
|  |         |                  |   |                |                  | (b)   |  |  |   |  |  |
|  |         |                  |   |                |                  | DUE TO, OR AS A CONSEQUENCE OF  |  |  |   |  |  |
|  |         |                  |   |                |                  | (c)   |  |  |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |         |                  |   |                |                  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |         |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |                |                  |   |  |  | 20. AUTOPSY?  |  |  |
|  |         |                  |   |                |                  |   |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 21a. EXTERNAL CAUSE WAS  |         |                  | 21b. TIME OF INJURY   |                |                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |  |   |  |  |
| UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         |                  | P.M. 19   |                |                  |   |  |  |   |  |  |
| 21d. INJURY OCCURRED   |         |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |                |                  | 21f. LOCATION   |  |  |   |  |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |         |                  |   |                |                  | STREET CITY OR TOWN COUNTY STATE  |  |  |   |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |                  |   |                |                  |   |  |  |   |  |  |
| ACTUAL SIGNATURE   |         |                  | TITLE (SPECIFY)   |                |                  |   |  |  | DATE SIGNED   |  |  |
| Ann M. Dixon, M.D.   |         |                  | Assistant   |                |                  |   |  |  | 11-20-80  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |         |                  | ADDRESS   |                |                  |   |  |  |   |  |  |
|  |         |                  | 111 Penn St.  |                |                  |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         |                  | 23b. DATE   |                |                  | 23c. NAME OF CEMETERY OR CREMATORY  |  |  | 23d. LOCATION   |  |  |
| Removal  |         |                  | 11/21/80  |                |                  |   |  |  | CITY OR TOWN COUNTY STATE   |  |  |
| 24. FUNERAL DIRECTOR   |         |                  | ADDRESS   |                |                  |   |  |  |   |  |  |
| Name   |         |                  | Balto., Md.   |                |                  |   |  |  |   |  |  |

NOV 28 1980



1952

AT 30 74 5

1700-2-001

1700-2-001

1700-2-001

1700-2-001

1700-2-001

1700-2-001

1700-2-001

1700-2-001



1700-2-001

1700-2-001

1700-2-001

1700-2-001

1700-2-001

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 0 0 0

REG. NO.

|   |  |   |  |   |  |  |  |   |  |
|---|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST MIDDLE LAST   |  | 2a. DATE OF DEATH   |  | MONTH DAY YEAR   |  | 2b. HOUR  |  |
| HOWARD T. DRUMMOND  |  |   |  | NOVEMBER 20, 1980   |  |  |  | 08:55 AM  |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  |
| Male  |  | Negro   |  | 4 MONTH 22 DAY 10 YEAR  |  | 70 YRS.  |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>       |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |
| N.Y.  |  | USA   |  |   |  | BALTIMORE CITY MD.   |  |   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| Baltimore   |  | THE JOHNS HOPKINS HOSPITAL  |  |   |  |  |  |   |  |
| 13a. STATE  |  |   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |  |
| MD  |  |   |  |   |  | Baltimore  |  | 526 N. Patterson Park Ave   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  |  |  |   |  |
| Oscar Drummond  |  |   |  | Emma Hall   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS   |  |  |  |   |  |
| No  |  | N/A   |  | Lillian Drummond 526 N. Patterson Pk.   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u>   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>15 MIN</u>  |  |
| 4100 } CONDITIONS, IF ANY, WHICH<br>GAVE RISE TO IMMEDIATE<br>CAUSE (a), STATING THE<br>UNDERLYING CAUSE LAST.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>PULMONARY EDEMA</u>  |  |   |  |   |  |  |  | 20 MIN  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>MYOCARDIAL INFARCTION</u>  |  |   |  |   |  |  |  | 45 MIN  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>CONGESTIVE HEART FAILURE</u>  |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that (H) (this hospital) attended the deceased from <u>NOV 18, 1980</u> , to <u>NOV 20, 1980</u> , that (L) (we) last saw the deceased alive on <u>Nov 20, 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><u>Steven T. Kariya</u>   |  |   |  | DEGREE<br><u>MD</u><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  |  | 22c. DATE SIGNED<br><u>11-20-80</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>STEVEN T. KARIYA</u>  |  |   |  | 22e. ADDRESS<br><u>JOHNS HOPKINS HOSPITAL, BALTIMORE MD 21205</u>   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |   |  |
| Burial  |  | 11/26/80  |  | King Memorial Pk.   |  | Baltimore CO. MD   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME  |  |   |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |
| Wm. C. March F/H 1101 E. North Ave.   |  |   |  | NOV 25 1980   |  | <u>[Signature]</u>   |  |   |  |



NOV 2 1980

*Handwritten signature*



FOR  
1- STATE  
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

28001

|  |         |  |  |   |  |   |  |                                      |  |   |  |       |  |      |  |           |  |
|--|---------|--|--|---|--|---|--|--------------------------------------|--|---|--|-------|--|------|--|-----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST  |  | MIDDLE  |  | LAST  |  | 2a. DATE KNOWN OF DEATH              |  | <input checked="" type="checkbox"/> MONTH |  | DAY   |  | YEAR |  | 2b. HOUR  |  |
| Francis Adrian DuBois  |         |  |  |   |  | DuBois  |  | 11 14 19 80                          |  |   |  |       |  |      |  | M         |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR.                                    |  | IF UNDER 24 HRS.                     |  | 7c. DATE PRONOUNCED DEAD                  |  | MONTH |  | DAY  |  | YEAR      |  |
| Male   | White   | Oct. 10, 1937  |  | 43 YRS.   |  |   |  |                                      |  | 11 14 19 80                               |  |       |  |      |  | 6:30 P.M. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED  |  | <input checked="" type="checkbox"/> NEVER MARRIED |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |   |  |       |  |      |  |           |  |
| Mass.  |         | USA  |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>            |  |   |  | Baltimore City                       |  |   |  |       |  |      |  | MD.       |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |  | 12b. KIND OF BUSINESS OR INDUSTRY                 |  |                                      |  |   |  |       |  |      |  |           |  |
| Baltimore  |         | University Hospital-S.T.U.   |  | Aircraft Mtn. Mech. Aviation  |  |   |  |                                      |  |   |  |       |  |      |  |           |  |
| 13a. STATE   |         | 13b. CITY OR TOWN  |  | 13c. STREET ADDRESS   |  |   |  |                                      |  |   |  |       |  |      |  |           |  |
| Maryland   |         | Harford  |  | Forest Hill   |  | 2313 Warfield Drive                               |  |                                      |  |   |  |       |  |      |  |           |  |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME   |  |   |  |   |  |                                      |  |   |  |       |  |      |  |           |  |
| Alphonse Adrian DuBois   |         | Madeline -- Sheridan   |  |   |  |   |  |                                      |  |   |  |       |  |      |  |           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |         | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS   |  |                                      |  |   |  |       |  |      |  |           |  |
| Yes  |         | 1955-1962 014-26-4425  |  | Mrs. Julia A. DuBois, Forest Hill, Md.  |  |   |  |                                      |  |   |  |       |  |      |  |           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |   |  |                                      |  |   |  |       |  |      |  |           |  |
| PART I DEATH WAS CAUSED BY:  |         |  |  |   |  |   |  |                                      |  |   |  |       |  |      |  |           |  |
| IMMEDIATE CAUSE (a)  |         |  |  |   |  |   |  |                                      |  |   |  |       |  |      |  |           |  |
| 4300 Subarachnoid hemorrhage   |         |  |  |   |  |   |  |                                      |  |   |  |       |  |      |  |           |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |  |  |   |  |   |  |                                      |  |   |  |       |  |      |  |           |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |         |  |  |   |  |   |  |                                      |  |   |  |       |  |      |  |           |  |
| (b) ruptured berry aneurysm  |         |  |  |   |  |   |  |                                      |  |   |  |       |  |      |  |           |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |  |  |   |  |   |  |                                      |  |   |  |       |  |      |  |           |  |
| (c)  |         |  |  |   |  |   |  |                                      |  |   |  |       |  |      |  |           |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).                      |         |  |  |   |  |   |  |                                      |  |   |  |       |  |      |  |           |  |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 20. AUTOPSY?  |  |   |  |                                      |  |   |  |       |  |      |  |           |  |
|  |         |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |  |   |  |                                      |  |   |  |       |  |      |  |           |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                      |         | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |  |                                      |  |   |  |       |  |      |  |           |  |
|  |         | P.M. 19  |  |   |  |   |  |                                      |  |   |  |       |  |      |  |           |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                |  |   |  |                                      |  |   |  |       |  |      |  |           |  |
|  |         |  |  |   |  |   |  |                                      |  |   |  |       |  |      |  |           |  |
| 22a. I certify that I took charge of the remains described above, held an  |         | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion   |  |   |  |   |  |                                      |  |   |  |       |  |      |  |           |  |
| death resulted from  |         | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |   |  |                                      |  |   |  |       |  |      |  |           |  |
| ACTUAL SIGNATURE   |         | TITLE (SPECIFY)  |  | DATE SIGNED   |  |   |  |                                      |  |   |  |       |  |      |  |           |  |
| Margarita A. Korell  |         | Assistant  |  | 11-15-80  |  |   |  |                                      |  |   |  |       |  |      |  |           |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |         | ADDRESS  |  |   |  |   |  |                                      |  |   |  |       |  |      |  |           |  |
| Margarita A. Korell, M.D.  |         | 111 Penn Street  |  |   |  |   |  |                                      |  |   |  |       |  |      |  |           |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE           |  |                                      |  |   |  |       |  |      |  |           |  |
| Removal  |         | Nov. 15, 1980  |  | Devanny-Condron FH  |  | Pittsfield-Berkshire, Mass.                       |  |                                      |  |   |  |       |  |      |  |           |  |
| 24. FUNERAL DIRECTOR NAME  |         | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |                                      |  |   |  |       |  |      |  |           |  |
| Howard K. McComas III, Abingdon, Md.   |         | NOV 18 1980  |  | Dorothy McCreedy  |  |   |  |                                      |  |   |  |       |  |      |  |           |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



X



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 0 0 2

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Opal M. Dugger</i>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>Nov. 8, 1980</i>                           |   | 2b. HOUR<br>M<br><i>M</i>  |
| 3. SEX<br><i>Female</i>   | 4. RACE<br><i>White</i>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>Sept. 25, 1922</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>58</i>  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7. BIRTHPLACE<br>STATE OR FOREIGN COUNTRY<br><i>Virginia</i>  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.                               |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>1356 Towson St. Balto. Md.</i> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Housewife</i> |   | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br><i>Maryland</i>   |  | 13b. COUNTY<br><i>Baltimore</i>   | 13c. CITY OR TOWN<br><i>Baltimore</i>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><i>1356 Towson St. Balto. Md.</i>   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Emmett ----- Louk</i>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Dolly Mae Kyle</i>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>216-32-1942</i>   |  | 17. INFORMANT<br>ADDRESS<br><i>Mr. Alston E. Dugger, Sr. Same as above</i>                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>uremia</i><br><i>1809</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>cancer cervix stage 4</i><br>6 months<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |   |  |   |  |
| 19a. DATE OF OPERATION<br><i>9/7/80</i>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>cancer cervix</i>  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>9/2/80</i> 19 <i>80</i> , to <i>11/8</i> 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>11/3/80</i> 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) did not view the body after death.                                 |  |   |  |   |  |
| 22b. SIGNATURE<br><i>William Prevas MD</i>  |  | DEGREE  |  | 22c. DATE SIGNED<br><i>11/10/80</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>William Prevas MD</i>   |  | 22e. ADDRESS<br><i>22 Greene St</i>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>  |  | 23b. DATE<br><i>Nov. 12, 1980</i>   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Glen Haven Mem. Park</i>                    |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Eden, Bowie, A A Co Maryland</i>  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>McCutty Funeral Home, 130 E. Fort Ave. Balto. Md.</i>  |  | ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR<br><i>NOV 12 1980</i>   | 25b. REGISTRAR'S SIGNATURE<br><i>Rita McCreedy</i>   |

MEDICAL CERTIFICATION

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

• • • • •

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

28003

|  |         |  |         |   |                            |   |   |   |       |   |  |
|--|---------|--|---------|---|----------------------------|---|---|---|-------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST  | MIDDLE  | LAST  | 2a. DATE KNOWN<br>OF DEATH |   | <input checked="" type="checkbox"/> MONTH | DAY   | YEAR  | 2b. HOUR  |  |
| Martin   |         | McVan  | Dunaway |   | 11                         |   | 29  | 19  | 80    | M   |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   |         | 6. AGE (IN YEARS)   | IF UNDER 1 YR.             | IF UNDER 24 HRS.  | 2c. DATE<br>PRONOUNCED<br>DEAD            |   | MONTH | DAY   |  |
| male   | black   | 5/25/21  |         | 59 YRS.   | MONTHS                     | DAYS  | 11  |   | 29    | 80  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |         | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |   | 2d. HOUR  |       |   |  |
| Balto., Md.  |         | U.S.   |         | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                    |                            | Baltimore City  |   | 2:13A   |       |   |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |         |   |                            | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |   | 12b. KIND OF BUSINESS OR INDUSTRY   |       |   |  |
| Baltimore  |         | 2222 Druid Hill Avenue   |         |   |                            |   |   |   |       |   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |         | 13a. STATE   |         | 13b. COUNTY   |                            | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS?  |       | 13e. STREET ADDRESS   |  |
| Md.  |         |  |         | Balto.  |                            | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 2222  |       | Druid Hill Ave.   |  |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME   |         | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)                 |                            | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT   |       | ADDRESS   |  |
| Unknown  |         | Unknown  |         | Yes   |                            | 215-18-7448   |   | Matilda Morphis   |       | 1806 Ashburton St.  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:   |         |  |         |   |                            |   |   |   |       | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                     |  |
| IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b>   |         |  |         |   |                            |   |   |   |       |   |  |
| 4292 { DUE TO, OR AS A CONSEQUENCE OF  |         |  |         |   |                            |   |   |   |       |   |  |
| (b) _____  |         |  |         |   |                            |   |   |   |       |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |  |         |   |                            |   |   |   |       |   |  |
| (c) _____  |         |  |         |   |                            |   |   |   |       |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |         |  |         |   |                            |   |   |   |       |   |  |
| 19a. DATE OF OPERATION   |         |  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                     |                            |   |   |   |       | 20. AUTOPSY?  |  |
|  |         |  |         |   |                            |   |   |   |       | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         |  |         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                            |                            |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |       |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |         |  |         | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)                        |                            |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |       |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |  |         |   |                            |   |   |   |       |   |  |
| ACTUAL SIGNATURE <i>H. Guard</i>   |         |  |         | TITLE (SPECIFY)<br>M.D. Assistant   |                            |   |   | DATE SIGNED 11/29/80  |       |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |         |  |         | ADDRESS   |                            |   |   |   |       |   |  |
| Hormez R. Guard, M.D.  |         |  |         | 111 Penn Street, Balto., MD 21201   |                            |   |   |   |       |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |         | 23b. DATE  |         | 23c. NAME OF CEMETERY OR CREMATORY  |                            | 23d. LOCATION<br>CITY OR TOWN                                       |   | COUNTY  |       | STATE   |  |
| Burial   |         | 12/4/80  |         | Mt. Auburn Cemetery   |                            | Balto., Md.   |   |   |       |   |  |
| 24. FUNERAL DIRECTOR<br>NAME   |         |  |         | ADDRESS   |                            |   |   | 25a. DATE REC'D. BY REGISTRAR   |       | 25b. REGISTRAR'S SIGNATURE  |  |
| C. Wainwright  |         |  |         | 2700 Edmondson Ave.   |                            |   |   | DEC 1 1980  |       | <i>Richard M. ...</i>   |  |



1604 BP  
DHMH-16 30M 2/80  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |   |  |
|---|--|--|--|---|--|---|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 8 0 2 8 0 0 4  |  |   |  |   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST MIDDLE LAST<br>SHERMAN DUNAWAY   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 03 80   |  | 2b. HOUR<br>2 45<br>A.M.  |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>BLACK   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6 18 20   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>60 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)<br>MD.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>CITY MD.  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BON SECOURS HOSP. |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |  |
| 13a. STATE<br>MD.   |  | 13b. COUNTY<br>BALTO.  |  | 13c. CITY OR TOWN<br>BALTO.   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>1933 W. LANVALE ST.  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>LUMBERT DUNAWAY   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>EULA SMITH  |  |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>UNKNOWN   |  | 16b. SOCIAL SECURITY NO.<br>218-01-5043  |  | 17. INFORMANT<br>ADDRESS<br>FLORENCE JENNINGS DUNAWAY 1933 W. Lanvale   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>5715 IMMEDIATE CAUSE (a) HEPATIC ENCEPHALOPATHY<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) CIRRHOSIS OF THE LIVER<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>1 WK.<br>YEARS. |  |  |  |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>SUSPECTED CANCER OF PANCREAS.   |  |  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-29, 19 80, to 11-03, 19 80, that (I) (we) last<br>saw the deceased alive on 11-02, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                 |  |  |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br>Oscar E. Fernandez M.D.   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br>11-03-80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>OSCAR E. FERNANDINI  |  |  |  | 22e. ADDRESS<br>BON SECOURS HOSP. BALTO, MD.<br>21223   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>11/8/80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn Cem.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore MD                                      |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H 1101 E. North Ave.   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 5 1980   |  | 25b. REGISTRAR'S SIGNATURE<br>P. J. McHenry   |  |   |  |

25 09 11

UNAWAY

UNAWAY

CD

05 11 0

BLK

WAVE

CITY

USA

MD

BALTIMORE

BALTIMORE

11 22 11 JANUARY 21

BALTO

MD

SMITH

WAVE

UNAWAY

UNAWAY

01-01-2018

UNAWAY

WAVE

UNAWAY

WAVE

UNAWAY

UNAWAY

08

11-02

08

11-02

11-02

11-02-20

UNAWAY

11-02-20

UNAWAY

UNAWAY



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 2 8 0 0 5<br>CERTIFICATE OF DEATH  |  |         |  |                            |   |  |   |  |  |  |
|---|--|---------|--|----------------------------|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |         | REG. NO.   |                            |   |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |         | 2a. DATE OF DEATH  |                            |   | 2b. HOUR   |   |  |  |  |
| FIRST MIDDLE LAST<br>LENA M. DUNFEE   |  |         | MONTH DAY YEAR<br>11 6 80  |                            |   | 1:00 A.M.  |   |  |  |  |
| 3. SEX  |  | 4. RACE |  | 5. DATE OF BIRTH           |   | 6. AGE (IN YEARS LAST BIRTHDAY)  |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                      |  |  |
| Female  |  | White   |  | June 28, 1910 <sup>8</sup> |   | 70   |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |         | 7b. CITIZEN OF WHAT COUNTRY?   |                            | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |
| Virginia  |  |         | United States  |                            |   |  | Baltimore City MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                            |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |   | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |  |
| Baltimore   |  |         | Church Hospital Corp.  |                            |   | House-wife   |   | Home   |  |  |
| 13a. STATE  |  |         | 13b. COUNTY  |                            | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS                          |  |
| Maryland  |  |         | -  |                            | Baltimore   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 2000 O'Dell Ave.                             |  |
| 14. FATHER'S NAME   |  |         | 15. MOTHER'S MAIDEN NAME   |                            |   |  |   |  |  |  |
| FIRST MIDDLE LAST<br>Richard - Church   |  |         | FIRST MIDDLE LAST<br>- - - UNKNOWN   |                            |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |         | 16b. SOCIAL SECURITY NO.   |                            | 17. INFORMANT ADDRESS   |  |   |  |  |  |
| NO  |  |         | 138-14-2772B   |                            | Warren Dunfee 2000 O'Dell Ave.  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIOVASCULAR ARREST</u><br><u>4960</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |         |  |                            |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |         |  |                            |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                            |   | 20a. AUTOPSY?  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |
|   |  |         |  |                            |   | YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |         | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                            | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |                            | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
|   |  |         |  |                            |   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11-6</u> , 19 <u>80</u> , to <u>11-6</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>11-6</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |         |  |                            |   |  |   |  |  |  |
| 22b. SIGNATURE  |  |         | DEGREE   |                            |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED   |  |  |
| <u>John A. Kieley</u>   |  |         | <u>M.D.</u>  |                            |   |  |   | <u>11-6-80</u>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |         | 22e. ADDRESS   |                            |   |  |   |  |  |  |
| JOHN A. KIELEY, M.D.  |  |         | CHURCH HOSPITAL CORPORATION<br>100 NORTH BROADWAY, BALTIMORE, MARYLAND 21231                           |                            |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |         | 23b. DATE  |                            | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |  |  |  |
| Burial  |  |         | Nov. 10, 1980  |                            | Crest Lawn Cemetery   |  | - Howard Co., Maryland  |  |  |  |
| 24. FUNERAL DIRECTOR  |  |         | 25a. DATE REC'D. BY REGISTRAR  |                            |   | 25b. REGISTRAR'S SIGNATURE   |   |  |  |  |
| Lilly & Zeiler Inc. 1901 Eastern Ave./21231   |  |         | NOV 7 1980   |                            |   | <u>John A. Kieley</u>  |   |  |  |  |

STANDARD 100-100000

and 100

STANDARD 100-100000

X

STANDARD 100-100000

STANDARD 100-100000

STANDARD 100-100000

STANDARD 100-100000

STANDARD 100-100000

STANDARD 100-100000

STANDARD 100-100000

STANDARD 100-100000

STANDARD 100-100000

STANDARD 100-100000

STANDARD 100-100000

STANDARD 100-100000

STANDARD 100-100000

STANDARD 100-100000

STANDARD 100-100000

STANDARD 100-100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |   |  |   |  |  |   |  |
|--|--|--|--|---|--|---|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   | 8 0 2 8 0 0 6                                |   |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  |   | 2a. DATE OF DEATH                            |   |  |  |   |  |
| FIRST MIDDLE LAST  |  |  |  |   | MONTH DAY YEAR                               |   |  |  |   |  |
| Joseph Dziadoz   |  |  |  |   | 11 10 1980                                   |   |  |  |   |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | 7b. HOUR   |   |  |
| Male   |  | Cauc.  |  | MONTH DAY YEAR  |  | 85 YRS.   |  | M  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |   |  |
| Poland   |  | U.S.A.   |  |   |  | Baltimore City  |  | MD   |   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  |  |   |  |
| Baltimore  |  | 118 N. Montford Ave.   |  |   |  | Laborer   |  |  |   |  |
| 13a. STATE   |  |  |  |   | 13b. COUNTY                                  |   | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  |
| Md.  |  |  |  |   |  |   | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME (FIRST MIDDLE LAST)  |  |  |  |   | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) |   |  |  |   |  |
| John Dziadoz   |  |  |  |   | Agnes Chmiel                                 |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  |   | 16b. SOCIAL SECURITY NO.                     |   | 17. INFORMANT ADDRESS  |  |   |  |
| Yes  |  |  |  |   | WW I   |   | 215-03-6052 Sophia Dziadoz 118 N. Montford Ave   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |   |  |   |  |  |   |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |   |  |   |  |  |   |  |
| IMMEDIATE CAUSE (a) Cardiac Arrest   |  |  |  |   |  |   |  |  |   |  |
| 2500   |  |  |  |   |  |   |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF Arteriosclerosis  |  |  |  |   |  |   |  |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  |   |  |   |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF Diabetes Mellitus   |  |  |  |   |  |   |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):  |  |  |  |   |  |   |  |  |   |  |
| Cerebrovascular Accident   |  |  |  |   |  |   |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |   |  |
|  |  |  |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |   |  |
|  |  | HOUR A.M. MONTH DAY YEAR   |  |   |  |   |  |  |   |  |
|  |  | P.M.   |  |   |  |   |  |  |   |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION   |  |   |  |  |   |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |  | STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/17 78 to 10/30/ 80, that (I) (we) last saw the deceased alive on 10/30/ 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |  |   |  |
| 22b. SIGNATURE   |  |  |  |   | DEGREE                                       |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED  |  |
| Abdul N. Rahman, M.D.  |  |  |  |   | M.D.   |   |  |  | 11/14/1980  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  |   | 22e. ADDRESS                                 |   |  |  |   |  |
| Abdul N. Rahman, M.D.  |  |  |  |   | 100 N. Broadway, Baltimore, Md. 21231        |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION   |  | STATE  |   |  |
| Burial   |  | 11/13/80   |  | Holy Redeemer Cem.  |  | Baltimore   |  | Md.  |   |  |
| 24. FUNERAL DIRECTOR   |  |  |  |   |  |   |  |  |   |  |
| NAME   |  |  |  |   | ADDRESS                                      |   |  |  |   |  |
| H. Dabrowski & Son   |  |  |  |   | 2818 E. Baltimore St.                        |   |  |  |   |  |

NOV 18 1980

October 11, 1962

Director

Washington, D.C.

30-1092

C.C.

File

Religious Div.

Re: [illegible]

Subject

118 N. [illegible]

Re: [illegible]

118 N. [illegible]

Re: [illegible]

Re: [illegible]

On file

Re: [illegible]

Re: [illegible]

Re: [illegible]

118 N. [illegible]

Re: [illegible]

Re: [illegible]

Re: [illegible]

Re: [illegible]

Re: [illegible]

Re: [illegible]

Re: [illegible]

Re: [illegible]

Re: [illegible]

118 N. [illegible]

118 N. [illegible]

118 N. [illegible]

Re: [illegible]

Re: [illegible]

Re: [illegible]

Re: [illegible]

118 N. [illegible]

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 2 8 0 0 7  
CERTIFICATE OF DEATH

FOR  
1. STATE  
REGISTRAR

REG. NO.

|  |   |   |  |   |  |
|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>HANNAH H. EASON</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 6 80</b>                |   | 2b. HOUR<br><b>4:56 AM</b>   |
| 3. SEX<br><b>FEMALE</b>  | 4. RACE<br><b>BLACK</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 16 29</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>51</b>                         |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>IF UNDER 24 HRS.  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>    |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)     |   | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br><b>Md</b>  |   | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>Balto.</b>                                   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>2528 Robb Street</b>   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Scott Heckstall</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Martha Turner</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES-GIVE WAR OR DATES)<br><b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>216-20-3684</b>  | 17. INFORMANT<br>ADDRESS<br><b>Robt. Eason 2528 Robb Street</b>      |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a): <b>Herniation of brain</b><br>DUE TO, OR AS A CONSEQUENCE OF (b): <b>Intracerebral bleed</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c): <b>HBP</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |   |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |   |   |  |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/6</b> 19 <b>80</b> to <b>11/6</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>11/6</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.)  |   |   |  |   |  |
| 22b. SIGNATURE<br><b>W. Carroll</b>  |   | DEGREE  |  | 22c. DATE SIGNED<br><b>11/6/80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CARROLL</b>  |   | 22e. ADDRESS<br><b>UM Hospital</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>11/13/80</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Crownsville VA</b>   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Crownsville Md.</b> |   |  |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br><b>WILLIAM C. MARCH 1101 E. NORTH AVENUE</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 10 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Hester/Helms</b>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE CITY

UNITED STATES DEPARTMENT OF JUSTICE

BALTIMORE

100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

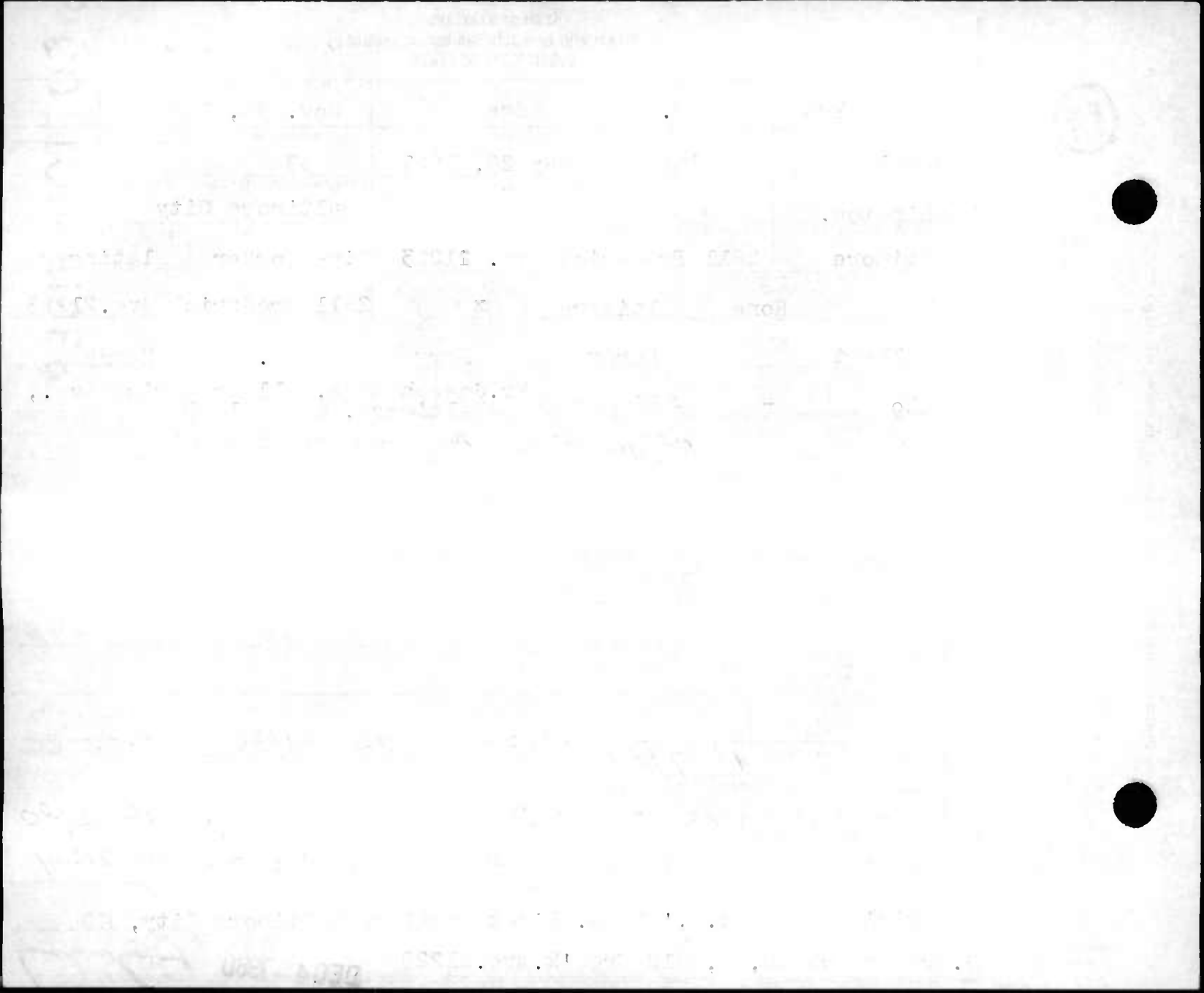
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 0 0 8

REG. NO.

|   |  |   |   |   |  |
|---|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Alma C. Edge   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Nov. 30, 1980  |   | 2b. HOUR<br>M  |
| 3. SEX<br>Female  | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>May 29, 1927  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>53 YRS                                 | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Washington, DC   | 7b. CITIZEN OF WHAT COUNTRY?<br>U S A  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2811 Frederick Ave. 21223 |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Line Worker                 | 12b. KIND OF BUSINESS OR INDUSTRY<br>Plating                              |  |
| 13a. STATE<br>MD  | 13b. COUNTY<br>None  | 13c. CITY OR TOWN<br>Baltimore  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>2811 Frederick Ave. 21223                          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Albert Hardy  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary A. Hardy  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No -  |  | 16b. SOCIAL SECURITY NO.<br>579 30 4015   | 17. INFORMANT ADDRESS<br>Mr. Joseph Edge, 2811 Frederick Ave.,<br>Baltimore, MD 21223           |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) METASTATIC CARCINOMA OF BREAST<br>1749<br>DUE TO, OR AS A CONSEQUENCE OF (b):<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>DUE TO, OR AS A CONSEQUENCE OF (c):<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |   |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |   |  |
| 21d. INJURY OCCURRED<br>AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/27/80 11/13 19 80 to 11/30 19 80, that (I) (we) last saw the deceased alive on 11/27/80 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |  |
| 22b. SIGNATURE<br>OSWALD  |  | DEGREE<br>MD  |   | 22c. DATE SIGNED<br>12/2/80   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>A. OSEI-WUSU MD  |  | 22e. ADDRESS<br>900 CAYEN AVE BALI MD 21229   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  | 23b. DATE<br>Dec. 3, '80   | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Olivet Cemetery   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore City, MD          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>G. Truman Schwab, PA, 3512  |  | ADDRESS<br>Fredk. Ave. 21229  |   | 25a. DATE REC'D. BY REGISTRAR<br>DEC 4 1980                               | 25b. REGISTRAR'S SIGNATURE<br>Jeffrey H. Hines   |





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 0 0 9

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>CHARLES JOSEPH EDWARDS</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 21 80</b>  |  | 2b. HOUR<br><b>5:50 A.M.</b>   |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>WHITE</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 31 17</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. <b>BALTIMORE CITY</b> OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD                         |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VAMC LOCH RAVEN, BALTIMORE, MD</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>MAILER</b>               | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>News Paper</b>                               |  |
| 13a. STATE<br><b>MARYLAND</b>  | 13b. COUNTY<br><b>A.A.</b>   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br><b>219 W. ARUNDEL ROAD 21225</b>                              |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOHN Thomas EDWARDS</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Amelia Leona FLOYD</b>  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>YES WW II</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>212 07 5123</b>  | 17. INFORMANT<br>ADDRESS<br><b>Doris Edwards same as 13 e</b>                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>VENTRICULAR ARRHYTHMIA</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>PREVIOUS MYOCARDIAL INFARCTIONS AND</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>PROBABLE VENTRICULAR ANEURYSM</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (a) (this hospital) attended the deceased from <b>NOVEMBER 18, 19 80</b> , to <b>NOVEMBER 21, 19 80</b> , that (b) (we) lost<br>saw the deceased alive on <b>NOVEMBER 21, 19 80</b> , and that in (c) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (d) (we) did not see the body after death.  |  |   |   |  |  |
| 22b. SIGNATURE<br><i>Evelyn Jackson</i>  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   | 22c. DATE SIGNED<br><b>11/21/80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Evelyn Jackson, MD</b>   |  | 22e. ADDRESS<br><b>3900 LOCH RAVEN BLVD, BALTIMORE, MD 21218</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>11/25/80</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem Pk</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glen Burnie A.A. Md.</b>            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>George J. Gonce</b>   |  | ADDRESS<br><b>Balto 21225</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 24 1980</b>                                  | 25b. REGISTRAR'S SIGNATURE<br><i>Robert H. Hines</i>   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-copy. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.



PLANT INDUSTRY

PLANT INDUSTRY

PLANT INDUSTRY

PLANT INDUSTRY

PLANT INDUSTRY

PLANT INDUSTRY

PLANT INDUSTRY

PLANT INDUSTRY

PLANT INDUSTRY

PLANT INDUSTRY

PLANT INDUSTRY

PLANT INDUSTRY

PLANT INDUSTRY

33

M

BALTIMORE

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death.

DHMH-16 30M 2/80  
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |   |  |  | REG. NO. 80 28010 |  |
|---|--|---|--|---|--|--|---|--|--|-------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>LOLA EDWARDS   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>NOVEMBER 19, 1980                             |  |   | 2b. HOUR<br>08:22 AM   |  |                   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Negro  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 2 10  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>70 YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |   |  |  |                   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                   |  |
| 13a. STATE<br>MD  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 13e. STREET ADDRESS<br>1605 N. Port St.  |  |                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Robert unknown Thomson  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Jane unknown   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |  |  |   |  |  |                   |  |
| 16b. SOCIAL SECURITY NO.<br>213-28-2676D  |  | 17. INFORMANT ADDRESS<br>D Horace Price 1605 N. Port St.  |  |   |  |  |   |  |  |                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u><br><u>4360</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>BRAINSTEM DYSFUNCTION</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>STROKE</u>  |  |   |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>3 MIN</u><br><u>24 HRS</u><br><u>10 MOS</u> |  |                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>HYPERTENSION</u>  |  |   |  |   |  |  |   |  |  |                   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |   |  |  |                   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |  |                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>NOV 9</u> , 19 <u>80</u> , to <u>NOV 19</u> , 19 <u>80</u> , that (I) (we) lost<br>saw the deceased alive on <u>NOV 19</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |   |  |  |                   |  |
| 22b. SIGNATURE<br><u>Steven T. Kariya</u>   |  |   |  | DEGREE<br><u>MD</u>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><u>11-19-80</u>  |  |                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>STEVEN T. KARIYA</u>  |  |   |  | 22e. ADDRESS<br><u>JOHNS HOPKINS HOSP, BALTIMORE MD 21205</u>   |  |  |   |  |  |                   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>Burial</u>   |  | 23b. DATE<br><u>11-22/80</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Charles Memorial Cemetery</u>  |  | 23d. LOCATION<br><u>Leonardtown St. Marys</u>  |   |  |  |                   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>W. Clarke Mattingley</u>   |  | ADDRESS<br><u>1101 E. North Ave.</u>  |  | 25. DATE REC'D. BY REGISTRAR<br><u>NOV 24 1980</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |   |  |  |                   |  |

0802 BP



1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |  |                            | 80 28011 |  |
|---|--|---|--|---|--|--|--|--|----------------------------|----------|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO.  |  |   |  |  |  |  |                            |          |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>JOSEPH F. EICHELMAN</b>   |  |   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>11 25 80</b>  |  |  | 2b. HOUR<br><b>5:30 AM</b> |          |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>01 16 91</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS<br><b>89 YRS. 11 9</b>                      |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |                            |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD</b>                             |  |  |                            |          |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. AGNES HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>AUTO PARTS</b>           |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>SELF-EMPLOYED</b>  |                            |          |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>HALETHORPE</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>SALESMAN 3400 WASHINGTON BOULEVARD</b>   |                            |          |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>JOHN EICHELMAN</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME MIDDLE LAST<br><b>MARY SCHARF</b>  |  |  |  |  |                            |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>YES WW I</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>215-32-6839</b>  |  | 17. INFORMANT<br><b>JAMES EICHELMAN</b>   |  | ADDRESS<br><b>2103 GAYLAWN DRIVE 21227</b>   |  |  |                            |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RECURRENT BOWEL OBSTRUCTIONS</b><br><b>1541</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>RECTAL ADENOCAR</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>6-20-80</b> |  |   |  |   |  |  |  |  |                            |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>JEJUNAL FISTULA</b>  |  |   |  |   |  |  |  |  |                            |          |  |
| 19a. DATE OF OPERATION<br><b>11-14-80 LAST</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>LYSIS OF ADHESIONS - SMALL BOWEL</b>   |  |   |  | 20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                            |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>RESIDENCE</b>  |  |   |  | 21c. NATURE OF INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)         |  |  |                            |          |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |                            |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6-3-80</b> , 19____, to <b>11-25-80</b> , 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |  |                            |          |  |
| 22b. SIGNATURE<br><b>W. McCardle</b>  |  |   |  | DEGREE<br><b>ATTENDING PHYSICIAN</b> <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  |  | 22c. DATE SIGNED<br><b>11-25-80</b>  |                            |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>W. McARDLE, M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>ST. AGNES HOSPITAL 900 S. CATON AVENUE</b>   |  |  |  |  |                            |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>11-28-80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>NEW CATHEDRAL</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>BALTIMORE CITY MARYLAND</b>                    |  |  |                            |          |  |
| 24. FUNERAL DIRECTOR NAME<br><b>HUBBARD FUNERAL HOME, INC.</b>  |  |   |  | ADDRESS<br><b>4107 WILKENS AVE. 21229</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 26 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |                            |          |  |

MEDICAL CERTIFICATION

99

BP

10/19/57 2007 1000

874

11

1725 (1725) 1725-1725



FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 28012

REG. NO.

|  |  |  |  |  |                |  |  |  |        |   |                |  |  |  |  |          |  |
|--|--|--|--|--|----------------|--|--|--|--------|---|----------------|--|--|--|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST MARY   |  | MIDDLE   | LAST EIERMAN   | 2a. DATE OF DEATH  |  | MONTH 11   | DAY 27 | YEAR 1980   | 2b. HOUR       | 8:45   | AM   |  |  |          |  |
| 3. SEX   |  | FEMALE   |  | 4. RACE  |                | CAUCASIAN  |  | 5. DATE OF BIRTH   |        | MONTH 04  |                | DAY 29   | YEAR 1889                                    |  |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?   |                | USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |        | 9. BALTIMORE CITY OR COUNTY OF DEATH  |                | CITY   |  |  |  |          |  |
| 10. CITY OR TOWN OF DEATH  |  | BALTO  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                | SINAI HOSPITAL   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |        | HOUSEWIFE   |                | 12b. KIND OF BUSINESS OR INDUSTRY  |  | AT HOME  |  |          |  |
| 13a. STATE   |  | MO   |  | 13b. COUNTY  |                | BALTO  |  | 13c. CITY OR TOWN  |        | INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                | 13d. STREET ADDRESS  |  | 4405 LIBERTY HEIGHTS DR                                  |  |          |  |
| 14. FATHER'S NAME  |  | FIRST LOUIS  |  | MIDDLE   | LAST ROSENTHAL | 15. MOTHER'S MAIDEN NAME   |  | FIRST HENRIETTA  |        | MIDDLE  | LAST HORNSTEIN |  |  |  |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | NO   |  | 16b. SOCIAL SECURITY NO.   |                | 214-01-8677D   |  | 17. INFORMANT  |        | JULIUS EIERMAN  |                | 6917 REISTERSTOWN RD., 2ND FL. BALTO., MD 21215  |  |  |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) SEPSIS<br>0389<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |  |                |  |  |  |        |   |                |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |                |  |  |  |        |   |                |  |  |  |  |          |  |
| ANEMIA CVA   |  |  |  |  |                |  |  |  |        |   |                |  |  |  |  |          |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  |                | 20a. AUTOPSY?  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |        | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?                          |                |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/> |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |  |                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) |  |  |        |   |                |  |  |  |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  |                | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |        |   |                |  |  |  |  |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 27 NOV 1980 to 27 NOV 1980, that (we) (we) lost saw the deceased alive on 27 NOV 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.  |  |  |  |  |                |  |  |  |        |   |                |  |  |  |  |          |  |
| 22b. SIGNATURE   |  |  |  |  |                |  |  |  |        | DEGREE  |                | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED   |  | 11-27-80 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  |  |                | 22e. ADDRESS   |  |  |        |   |                |  |  |  |  |          |  |
| ARTHUR M. LEBSON   |  |  |  |  |                | 7640 FORDS LANE 21215  |  |  |        |   |                |  |  |  |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |                | 23d. LOCATION  |  |  |        |   |                |  |  |  |  |          |  |
| BURIAL   |  | 11/30/80   |  | DRUID RIDGE  |                | BALTIMORE COUNTY MARYLAND  |  |  |        |   |                |  |  |  |  |          |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  |                | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |        |   |                |  |  |  |  |          |  |
| SOL LEVINSON & BROS., INC.<br>6010 REISTERSTOWN RD. BALTO., MD 21215   |  |  |  |  |                | DEC 3 1980   |  | [Signature]  |        |   |                |  |  |  |  |          |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 0 1 3

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |  |  |   |   |   |  |
|---|--|--|--|---|--|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Edith E. Einhorn</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 23 80</b>                         |   | 2b. HOUR<br><b>852 AM</b>                  |  |   |   |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>CAUCASIAN</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>05 JUNE 28 05</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b>   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MASSACHUSETTS</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD                     |   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>   |   |  |
| 13a. STATE<br><b>MARYLAND</b>   |  |  | 13b. COUNTY<br><b>BALTIMORE</b>  |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>      |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>APT. 402<br/>3809 CLARKS LA. #21215</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ABRAHAM EDELSTEIN</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>CECELIA LOEB</b>           |   |  |  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>219-22-1415B</b> |   | 17. INFORMANT<br><b>MR. JOSEPH EINHORN</b> |  | APT. 402  |   | BALTO., MD 21215  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Ventricular Fibrillation</b><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Myocardial infarction, Acute</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>1</b> |  |  |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>(R) Hemisphere Stroke</b>   |  |  |  |   |  |  |   |   |   |  |
| 19a. DATE OF OPERATION<br><b>11/23</b>  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Hemisphere Stroke</b>   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 21</b> , 19 <b>80</b> , to <b>Nov 23</b> , 19 <b>80</b> , that (I) (we) lost<br>saw the deceased alive on <b>11/23</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death.                           |  |  |  |   |  |  |   |   |   |  |
| 22b. SIGNATURE<br><b>Paul Schwartz</b>  |  |  |  | DEGREE<br><b>M.D.</b>   |  |  |   | 22c. DATE SIGNED<br><b>11/23/80</b>   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Paul Schwartz M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>Sinai Hospital Belvedere, Greenspring 21215</b>  |  |  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>11/24/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BETH EL MEMORIAL PARK</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>RANDALLSTOWN BALTO. MD</b>          |   |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 25 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                     |   |   |   |  |
| 6010 REISTERSTOWN RD. BALTO., MD 21215  |  |  |  |   |  |  |   |   |   |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

01005

000

RECEIVED

NOV 2 1900

~~RECEIVED~~

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |   |  |  |  |  |  | 8028014                                      |
|--|--|---|--|---|--|--|--|--|--|--|
| 1 - STATE REGISTRAR  |  |   |  |   |  |  |  |  |  | REG. NO.                                     |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>ELIZABETH AILEEN ELGIE   |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>NOVEMBER 23, 1980                             |  | 2b. HOUR<br>4:02AM   |  |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>11/3/1954 YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>26 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>CANADA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>CANADA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                           |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>ADMINISTRATION   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>DUN & BRADSTREET  |  |  |
| 13a. STATE<br>GEORGIA  |  |   |  | 13b. COUNTY<br>---  |  | 13c. CITY OR TOWN<br>ATLANTA   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>WILLIAM A. ELGIE   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>THERESA A. MCCORMICK   |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>221.40.4440  |  | 17. INFORMANT<br>T. AILEEN ELGIE<br>ADDRESS<br>LAKE CLUB APTS.<br>DOVER, DELAWARE 19901   |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIO-RESPIRATORY COLLAPSE</u><br>2362<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>ASCITES, RECURRENT, SEP315</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>RECURRENT GRANULOSA CELL TUMOR</u><br>5/14/80 → 11/23/80<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>NONE.</u> |  |   |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION<br>MAY, 1980  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>GRANULOSA CELL TUMOR  |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in item 1b, PART 1 OR PART 2)<br>NO INJURY   |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from <u>OCT 27</u> , 19 <u>80</u> , to <u>NOV 23</u> , 19 <u>80</u> , that (we) last saw the deceased alive on <u>NOV 23</u> , 19 <u>80</u> , and that in (my) (we) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |  |  |  |
| 22b. SIGNATURE<br>D. Hurlock MD  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |  |  | 22c. DATE SIGNED<br>11/23/80   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>D. HURLOCK, MD.   |  |   |  | 22e. ADDRESS<br>% JOHNS HOPKINS HOSPITAL<br>BALTIMORE, MD.  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>CREMATION  |  | 23b. DATE<br>11/24/1980   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>GREEN MOUNT CEMETERY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MARYLAND                     |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>WALTER BROOKS BRADLEY INC., DUNDALK MD 21222   |  |   |  | DATE REC'D. BY REGISTRAR<br>NOV 28 1980   |  | 25. REGISTRAR'S SIGNATURE<br>[Signature]   |  |  |  |  |

BP

2021 8 2 第14次

MICU/7 1 138 50 91 JMH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the physician within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by a physician, it is to be retained by the funeral director and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon patient. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in office.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 2 8 0 1 5  
CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |   |  |  |
|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>SYLVIA D. ELLERBE  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>NOVEMBER 15, 1980  |  | 2b. HOUR<br>9:01 <sup>PM</sup>   |
| 3. SEX<br>Female  | 4. RACE<br>Black  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 27 33  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>47  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland  | 13b. COUNTY   | 13c. CITY OR TOWN<br>Baltimore  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>2615 Beryl Avenue   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Purvis  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mabel Whitley  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  | (IF YES, GIVE WAR OR DATES)   | 16b. SOCIAL SECURITY NO.  | 17. INFORMANT<br>ADDRESS<br>Howard Ellerbe 2801 E. Biddle Street                                |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Septic Shock</u><br><u>4275</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>pneumococcal pneumonia</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <u>Cardiac arrest</u> |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |   |   |   |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/15</u> , 19 <u>80</u> , to <u>11/15</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>11/15</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.     |   |   |   |  |  |
| 22b. SIGNATURE<br><u>Susan Mac Donald</u>   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>SUSAN MAC DONALD   |   | 22e. ADDRESS<br>Johns Hopkins   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |   | 23b. DATE<br>11/21/80   | 23c. NAME OF CEMETERY OR CREMATORY<br>Mount Calvary Cemetery                                    |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore MD   |
| 24. FUNERAL DIRECTOR<br>NAME<br>WILLIAM C. MARCH FUNERAL HOME INC.  |   | 1101 E. North Ave<br>ADDRESS  |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 19 1980   | 25b. REGISTRAR'S SIGNATURE<br><u>Patricia McElroy</u>  |

MEDICAL CERTIFICATION

200

RECEIVED  
JAN 23 1961  
AIR MAIL  
T 7 50 PM '61

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 0 1 6

REG. NO.

|   |  |   |  |  |  |  |  |   |  |
|---|--|---|--|--|--|--|--|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>GERTRUDE FLORENCE                   |  | MIDDLE<br>T. G.   |  | ELES AKA<br>ELLIS  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>11 10 80   |  | 2b HOUR<br>M                              |  |
| 3 SEX<br>FEMALE   |  | 4 RACE<br>WHITE   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>2 8 1888  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>92 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND                      |  | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |  |   |  |
| 10 CITY OR TOWN OF DEATH<br>BALTIMORE                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(GIVE FACILITY, GIVE STREET ADDRESS)<br>BON SECOURS HOSPITAL |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOMEMAKER                   |  | 12b KIND OF BUSINESS OR INDUSTRY<br>---   |  |
| 13a STATE<br>MARYLAND   |  | 13b COUNTY<br>---   |  | 13c CITY OR TOWN<br>BALTIMORE  |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e STREET ADDRESS<br>2339 ANNAPOLIS ROAD |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>CHARLES NEALE                    |  |   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>CATHERINE IMHOFF   |  |  |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO |  | 16b SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>---  |  | 17 INFORMANT<br>EARL D. ELLIS  |  | ADDRESS<br>5538 ASHBOURNE ROAD   |  |   |  |

|  |  |   |  |   |  |   |  |  |  |
|--|--|---|--|---|--|---|--|--|--|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ASCVD</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>OLD AGE</u>   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>DEHYDRATION</u>   |  |   |  |   |  |   |  |  |  |
| 19a DATE OF OPERATION<br>---   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED<br>---                |  |   |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from <u>1978</u> to <u>11/10</u> 19 <u>80</u> , that (I) (we) lost<br>saw the deceased alive on <u>11/10</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |  |  |
| 22b SIGNATURE<br><u>Imder Singh</u>  |  |   |  | DEGREE<br><u>MD</u><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  | 22c DATE SIGNED  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>IMDER SINGH MD</u>  |  |   |  | 22e ADDRESS<br><u>2301 Annapolis Rd Balto 21230</u>   |  |   |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  | 23b DATE<br>11/14/80  |  | 23c NAME OF CEMETERY OR CREMATORY<br>LOUDON PARK CEMETERY   |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE --- MD.                      |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>HUBBARD FUNNELL HOME 4107 WILKENS AVE   |  |   |  | 25a DATE REC'D. BY REGISTRAR<br>NOV 14 1980   |  | 25b REGISTRAR'S SIGNATURE<br><u>Anthony McBrady</u>                                 |  |  |  |

CHURCH OF THE HOLY TRINITY

1822

OLD AGE

DEATH

1822

no

11/10

11/10

no

11/10

1822



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at \_\_\_\_\_

3

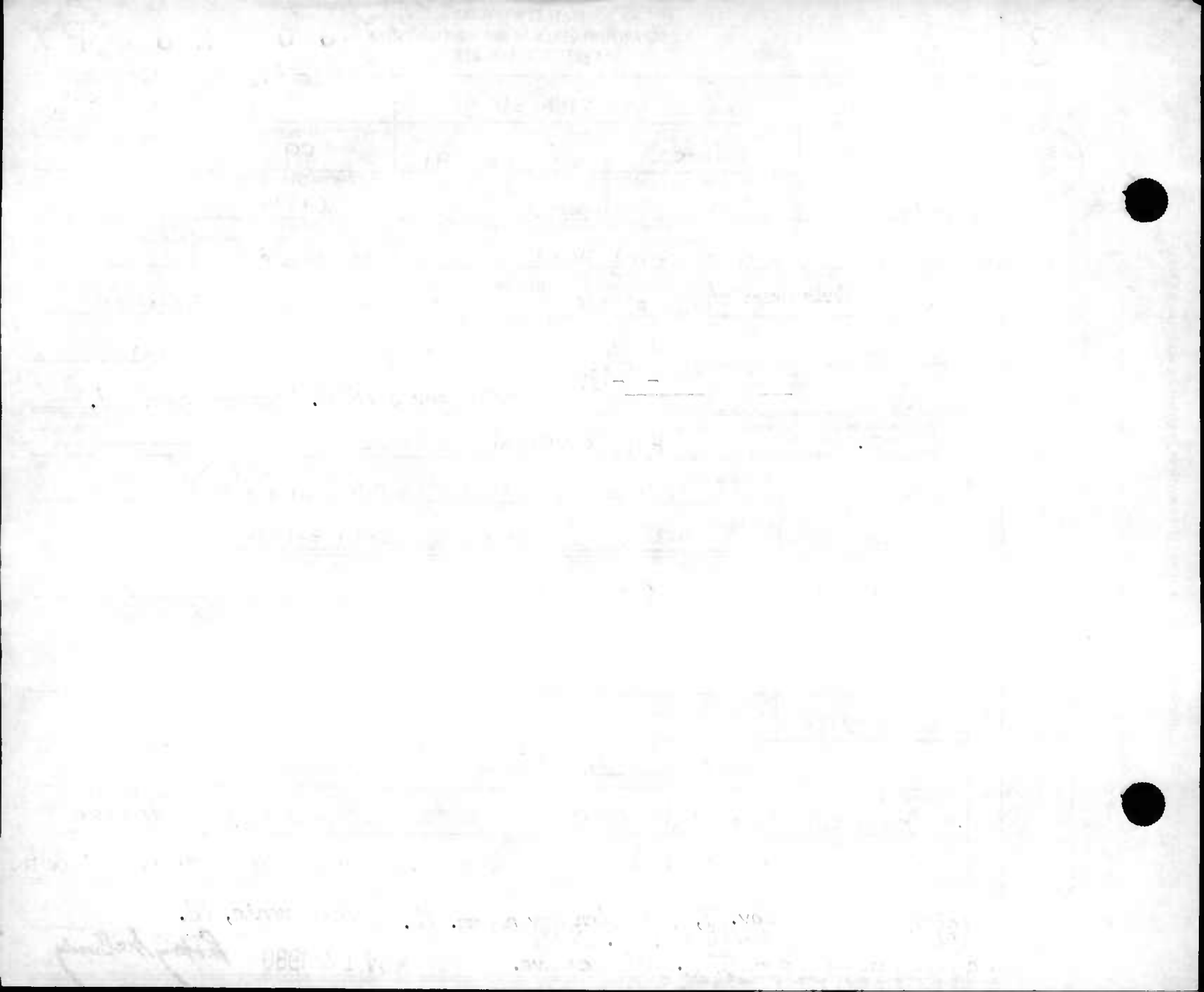
1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 0 1 7

REG. NO.

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MARY MIDDLE ENUOLEY LAST  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>11 12 80                             |  | 2b. HOUR<br>8 <sup>15</sup> a.m.  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>white   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>01 06 91  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>89 YRS  |  | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                     |  | 8. CITIZEN OF WHAT COUNTRY?<br>USA  |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>CITY   |  | 10. CITY OR TOWN OF DEATH<br>Balto.                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>S. Balto. Gen'l. Hosp.             |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>housewife  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  | 13a. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 13b. STREET ADDRESS<br>114 W. Furnace Branch Rd  |  | 14. FATHER'S NAME<br>FIRST George MIDDLE LAST Hadley                     |  | 15. MOTHER'S MAIDEN NAME<br>FIRST Christina MIDDLE LAST Fisher  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO<br>213-74-4399                                   |  | 17. INFORMANT<br>ADDRESS<br>Doris Groves 114 W. Furnace Branch Rd.  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) HYPOTENSION<br>2040<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) SEPSIS + HYPOVOLEMIA (SEVERE ANEMIA)<br>(c) ACUTE LYMPHOCYTIC LEUKEMIA |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:<br>MYOCARDIAL INFARCTION  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                         |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19               |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/25, 1980, to 11/12, 1980, that (I) (we) last saw the deceased alive on 11/12, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                 |  |  |  |   |  |
| 22b. SIGNATURE<br>Barbara Fretwell MD  |  | DEGREE   |  | 22c. DATE SIGNED<br>11/12/80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Barbara Fretwell  |  | 22e. ADDRESS<br>S. Balto. Gen'l. Hosp. 3001 S. Hanover St, Balto.        |  | 22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>Nov. 15, 1980   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Glen Haven Mem. Pk.   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Glen Burnie, Md.   |  | 24. FUNERAL DIRECTOR<br>NAME<br>McULLY Funeral Home 237 E. Patapsco Ave. |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 12 1980  |  |
| 25b. REGISTRAR'S SIGNATURE<br>R. J. Brady  |  |  |  |   |  |

BP \_\_\_\_\_



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 0 1 8

REG. NO.

|  |   |  |  |  |                                   |  |          |
|--|---|--|--|--|-----------------------------------|--|----------|
| 1 - FOR<br>STATE<br>REGISTRAR  |   | 2a. DATE OF DEATH  |  | MONTH  | DAY                               | YEAR   | 2b. HOUR |
| 1 DECEASED NAME<br>(TYPE OR PRINT)   |   | FIRST  | MIDDLE   | LAST   |                                   |  |          |
| Idella   |   | Ennis  |  |  |                                   | 11   | 18 80    |
| 3 SEX  | 4 RACE  | 5 DATE OF BIRTH  | 6 AGE (IN YEARS LAST BIRTHDAY)                                   | # UNDER 1 YEAR   | # UNDER 24 HRS                    |  |          |
| Female   | Black   | MONTH DAY YEAR   | 57 YRS.  | MONTHS DAYS  | HOURS MIN.                        |  |          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH                              |  |                                   |  |          |
| not known  | US  |  | Baltimore City MD.   |  |                                   |  |          |
| 10 CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(If not in such facility, give street address) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |          |
| Baltimore  | University of Maryland Hospital.  |  | Housewife  |  |                                   |  |          |
| USUAL RESIDENCE (If nursing home or other institution, give residence before admission)  |   | 13a. INSIDE CITY LIMITS?   | 13c. STREET ADDRESS  |  |                                   |  |          |
| 13a. STATE   | 13b. COUNTY   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  | 1041 W. Baltimore St.  |  |                                   |  |          |
| Maryland   | Baltimore City  |  |  |  |                                   |  |          |
| 14 FATHER'S NAME   |   | 15 MOTHER'S MAIDEN NAME  |  |  |                                   |  |          |
| FIRST  | MIDDLE  | LAST   | FIRST  | MIDDLE   | LAST                              |  |          |
| Fred   |   | James  | Lizzie   |  | James                             |  |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |   | 16b. SOCIAL SECURITY NO.   |  | 17 INFORMANT ADDRESS   |                                   |  |          |
| NO   |   |  |  |  |                                   |  |          |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Myocardial Infarction</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>11/18/80<br>11/15/80 |   |  |  |  |                                   |  |          |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |   |  |  |  |                                   |  |          |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |          |
|  |   |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                   |  |          |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                   |  |          |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/15, 1980, to 11-18, 1980, that (I) (we) last saw the deceased alive on 11-18, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |   |  |  |  |                                   |  |          |
| 22b. SIGNATURE   |   | DEGREE   |  | 22c. DATE SIGNED   |                                   |  |          |
| David E Kelley   |   | MD   |  | 11/18/80   |                                   |  |          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |   | 22e. ADDRESS   |  |  |                                   |  |          |
| David E Kelley   |   | University of Maryland Hospital, Balt., MD.  |  |  |                                   |  |          |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |   | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |                                   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                     |          |
| BURIAL   |   | 11/22/80   |  | MONT. AUBURN CEM.  |                                   | Baltimore  |          |
| 24 FUNERAL DIRECTOR<br>NAME  |   | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR  |                                   | 25b. REGISTRAR'S SIGNATURE                                     |          |
| BROWN-THOMPSON F. H.   |   | 1913 W. BALLO ST.  |  | NOV 21 1980  |                                   | P. Brown Thompson  |          |

OF BUREAU OF  
PROPERTY, CH. 12, U.S. A.  
BUREAU OF PROPERTY, CH. 12, U.S. A.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 0 1 9

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |   |   |   |   |  |
|--|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>MARGARET JEANNETTE ENOS</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 23 80</b>                                |   | 2b. HOUR<br><b>7:30a M</b>   |
| 3. SEX<br><b>FEMALE</b>  | 4. RACE<br><b>WHITE</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>02 15 98</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82 YRS.</b><br>IF UNDER 1 YEAR: MONTHS DAYS<br>IF UNDER 24 HRS: HOURS MIN |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST AGNES HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SEAMSTRESS</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>CLOTHING</b>   |
| 13a. STATE<br><b>MARYLAND</b>  |   |   | 13b. COUNTY<br><b>BALTIMORE</b>   | 13c. CITY OR TOWN<br><b>ARBUTUS</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>GEORGE J. FOHS</b>  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>                       |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>214-24-2706</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>WILLIAM L. ENOS, JR. 191 OAKLEE VILLAGE</b>                                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4280 Cerebro vascular accident</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>congestive heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |   |   |   |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)                                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |   |   |   |   |  |
| 22b. SIGNATURE<br><b>ARUNKUMAR</b>   |   | DEGREE  |   | 22c. DATE SIGNED<br><b>11/23/80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ARUNKUMAR</b>  |   | 22e. ADDRESS<br><b>900 CATON AVE BALTIMORE MD 21229</b>   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   | 23b. DATE<br><b>11-26-80</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LORRAINE PARK</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>WOODLAWN BALTIMORE MD.</b>                                     |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>HUBBARD FUNERAL HOME, INC.</b>  |   | ADDRESS<br><b>4107 WILKENS AVE.</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 24 1980</b>   |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

OFFICE OF THE SECRETARY  
DEPARTMENT OF THE ARMY  
WASHINGTON, D. C. 20315



BALTIMORE CITY

PT ARMED HOSPITAL

BALTIMORE

DATE: 10-1-50

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |   |  |   |  |   |                       | 8 0 2 8 0 2 0  |  |
|--|--|--|--|---|--|---|--|---|-----------------------|--|--|
| 1 - FOR STATE REGISTRAR  |  |  |  |   |  |   |  |   |                       | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Daisy E. Ensor   |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 11, 1980  |  |   | 2b. HOUR<br>6:00 P.M. |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Aug. 25, 1888   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>92 YRS   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS   |                       | 7. IF UNDER 1 YEAR<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>       |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |   |                       |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>303 S. Calhoun Street |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Teacher                     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Music                                |                       |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>303 S. Calhoun Street 21223                        |                       |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William J. Ensor   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Emma C. Nicholson  |  |   |  |   |                       |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br>ADDRESS<br>Mrs Alverta M. Courtney (as above)                                  |  |   |                       |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u><br>4292<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <u>Antenatal cardiac anomaly</u><br>(c) <u>—</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |  |  |  |   |  |   |  |   |                       | APPROXIMATE INITIAL PERIOD OF INCUBATION<br><u>—</u>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>CVA-</u>  |  |  |  |   |  |   |  |   |                       |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |   |                       |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |                       |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10-28</u> 19 <u>80</u> to <u>11-11</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>10-28</u> 19 <u>80</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |   |                       |  |  |
| 22b. SIGNATURE<br><u>[Signature]</u>   |  |  |  | DEGREE<br><u>MD</u><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br>11-12-80  |                       |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>MANCOUN D. ARVERNE MD</u>  |  |  |  | 22e. ADDRESS<br><u>1540 N. Bait St. Balt 4225</u>   |  |   |  |   |                       |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>11/14/1980  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Western   |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland         |                       |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>G. Truman Schwab   |  |  |  | ADDRESS<br>3512 Frederick Ave.  |  | DATE REG'D BY REGISTRAR<br>NOV 19 1980  |  | REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                               |                       |  |  |

20

0-1, 1-1, 1-2

0-1

1-2

0-1, 1-1, 1-2

1-2

0-1, 1-1, 1-2

...

1-2

0-1, 1-1, 1-2

1-2

0-1, 1-1, 1-2

1-2

1-2

0-1, 1-1, 1-2

1-2

0-1, 1-1, 1-2

1-2

1-2

0-1, 1-1, 1-2

1-2

0-1, 1-1, 1-2

1-2

0-1, 1-1, 1-2

1-2

0-1, 1-1, 1-2

1-2

0-1, 1-1, 1-2

0-1, 1-1, 1-2

0-1, 1-1, 1-2

0-1, 1-1, 1-2

1-2

0-1, 1-1, 1-2

1-2

0-1, 1-1, 1-2

0-1, 1-1, 1-2

1-2

0-1, 1-1, 1-2

0-1, 1-1, 1-2

0-1, 1-1, 1-2

1-2

0-1, 1-1, 1-2

1-2

0-1, 1-1, 1-2



3

1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

2 8 0 2 1

REG. NO.

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Mary A. Epps</i>  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><i>11/6/80</i>                   |  | 2b HOUR<br><i>10:18 A</i>  |  |
| 3. SEX<br><i>Female</i>  |  | 4. RACE<br><i>Negro</i>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>3 22 1904</i>   |  |
| 6. AGE<br>(IN YEARS LAST BIRTHDAY)<br><i>76</i>  |  | 7. CITIZEN OF WHAT COUNTRY?<br><i>U. S. A.</i>                         |  | 8. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City MD.</i>  |  |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Virginia</i>  |  | 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Provident Hospital</i> |  |
| 12. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>12a STATE<br><i>Maryland</i>  |  | 12b COUNTY<br><i>Baltimore</i>   |  | 12c INSIDE CITY LIMITS?<br><i>YES</i> NO <input type="checkbox"/>  |  |
| 13. STREET ADDRESS<br><i>623 Pitcher Street</i>  |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Mollie Moore</i>          |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Mollie Moore</i>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.<br><i>220-64-8545</i>                         |  | 17. INFORMANT<br>ADDRESS<br><i>Horace Epps 623 Pitcher Street</i>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>STROKE post Right Hemispheric</i><br><i>1536</i><br>DUE TO OR AS A CONSEQUENCE OF<br><i>2nd stroke, right side</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br><i>2nd stroke, right side</i><br>DUE TO OR AS A CONSEQUENCE OF<br><i>2nd stroke, right side</i><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>10/17 80</i>     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><i>11/6 80</i>  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>10/17</i> , 19 <i>80</i> , to <i>11/6</i> , 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>11/6</i> , 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |
| 22b. SIGNATURE<br><i>G. Franklin Phillips M.D.</i>   |  |  |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>G. Franklin Phillips M.D.</i>  |  |  |  | 22e. ADDRESS   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>   |  | 23b. DATE<br><i>11/10/80</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Baltimore Nat. Cem. Baltimore Co., Maryland</i>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Wm. C. March F/H 1101 East North Ave.</i>   |  | 25a. DATE REC'D. BY REGISTRAR<br><i>NOV 10 1980</i>                    |  | 25b. REGISTRAR'S SIGNATURE<br><i>Robert M. Brady</i>   |  |

MEDICAL CERTIFICATION

99

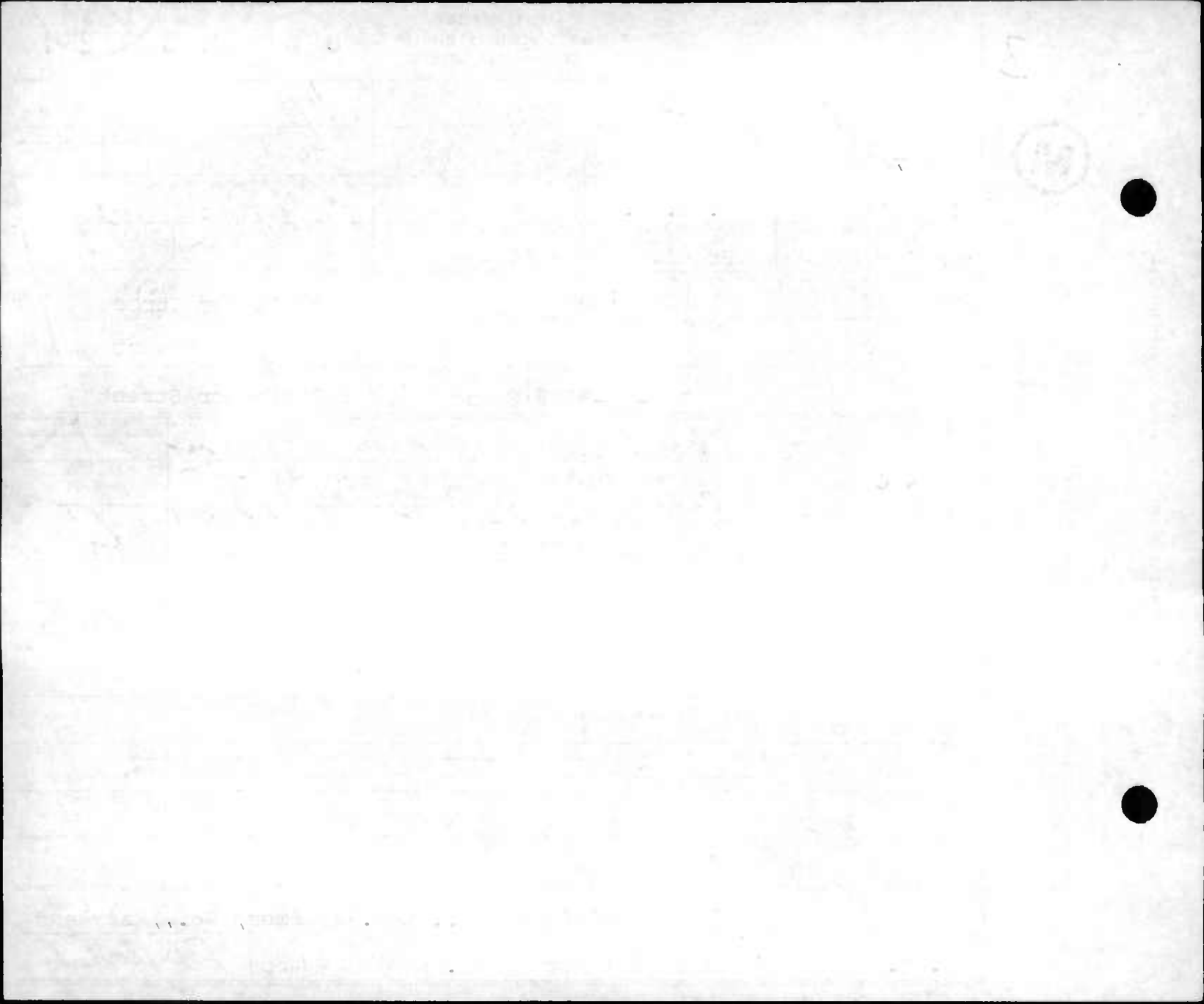
1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |  | REG. NO. 80 28022 |  |
|---|--|--|--|---|--|---|--|--|--|-------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>IRVIN</b> <b>EPSTEIN</b>   |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 10 80</b>  |  | 2b. HOUR<br>M<br><b>4:15 A</b>   |  |                   |  |
| 3. SEX<br><b>M</b> <b>A</b> <b>L</b> <b>E</b>   |  | 4. RACE<br><b>W</b> <b>H</b> <b>I</b> <b>T</b> <b>E</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>05 12 16</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><del>63</del> <b>64</b> YRS.                                 |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. <b>BALTIMORE CITY OR COUNTY OF DEATH</b><br><b>CITY</b> MD.                                  |  |  |  |                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sinai Hospt.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>PRINCIPAL</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>BALTO. CITY SCHOOLS</b>  |  |                   |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTO.</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>6602 Chelwood Rd 21209</b>   |  |                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOEL</b> <b>EPSTEIN</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>SADIE</b> <b>SCHECHTER</b>  |  |   |  |  |  |                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES YES OR UNKNOWN) (IF YES, GIVE WAR OR YEARS)<br><b>YES</b> <b>WWII-ARMY</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>213-34-0636</b>   |  | 17. INFORMANT <b>MRS. ROSE EPSTEIN</b><br><b>6602 CHELWOOD RD. BALTO., MD 21209</b>   |  |   |  |  |  |                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>1519</b> IMMEDIATE CAUSE (a) <b>Gastric Carcinoma w/ Metastasis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |   |  |  |  |                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |   |  |  |  |                   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |                   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |                   |  |
| 22a. I certify that (i) (this hospital) attended the deceased from <b>OCT 29</b> 19 <b>80</b> , to <b>NOV 10</b> 19 <b>80</b> , that (i) (we) lost the deceased given on <b>Nov 9</b> 19 <b>79</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.   |  |  |  |   |  |   |  |  |  |                   |  |
| 22b. SIGNATURE<br><b>Claudio Levin</b>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br><b>11/10/80</b>  |  |                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Claudio Levin</b>   |  |  |  | 22e. ADDRESS<br><b>Sinai Hospital</b>   |  |   |  |  |  |                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>11/11/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SHAAREI ZION</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ROSEDALE BALTO MD</b>                          |  |  |  |                   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>SOL LEVINSON &amp; BROS., INC.</b><br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 12 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Harry M. Brady</b>   |  |  |  |                   |  |


APR 11 1963

8 11 63

APR 11 1963

**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

|  |             |   |   |  |   |   |   |  |
|--|-------------|---|---|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |             |   | 2a. DATE KNOWN OF DEATH ESTI- MATED                                 |  |   | 2b. HOUR  |   |  |
| Bessie M. Evans  |             |   | 11 11 80  |  |   | 11:13 AM  |   |  |
| 3. SEX   | 4. RACE     | 5. DATE OF BIRTH  | 6. AGE (IN YEARS)   | IF UNDER 1 YR.   | IF UNDER 24 HRS.  | 7c. DATE PRONOUNCED DEAD  | 2d. HOUR  |  |
| Female   | Black       | 9 22 13   | 67 YRS.   | MONTHS   | DAYS  | 11 12 80  | 11:13 AM  |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |             | 7b. CITIZEN OF WHAT COUNTRY?  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH  |   |  |
| Maryland   |             | USA   |   |  |   | Baltimore City, MD.   |   |  |
| 10. CITY OR TOWN OF DEATH  |             | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                         |   | 12b. KIND OF BUSINESS OR INDUSTRY            |
| Baltimore  |             | 3824 W. Cold Spring Lane  |   |  |   |   |   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |             |   |   |  |   |   |   |  |
| 13a. STATE   | 13b. COUNTY | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS  |   |   |   |  |
| Maryland   |             | Baltimore   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 3824 W. Coldspring Lane  |   |   |   |  |
| 14. FATHER'S NAME  |             |   | 15. MOTHER'S MAIDEN NAME  |  |   |   |   |  |
| Webster Peach  |             |   | Lila Shorter  |  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |             |   | 16b. SOCIAL SECURITY NO.  |  |   | 17. INFORMANT ADDRESS   |   |  |
| No   |             |   | 216-12-3527   |  |   | Earline Thomas 5017 Truesdale Avenue  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b><br>4292 } CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a) STATING THE UNDERLYING CAUSE LAST.<br>(b) }<br>(c) }<br>DUE TO, OR AS A CONSEQUENCE OF   |             |   |   |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |             |   |   |  |   |   |   |  |
| 19a. DATE OF OPERATION   |             |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                   |  |   |   | 20. AUTOPSY?  |  |
|  |             |   |   |  |   |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |             |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |             |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)         |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                |   |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |             |   |   |  |   |   |   |  |
| ACTUAL SIGNATURE   |             |   | TITLE (SPECIFY)   |  |   | DATE SIGNED   |   |  |
|   |             |   | Deputy Chief  |  |   | 11/12/80  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |             |   | ADDRESS   |  |   |   |   |  |
| Thomas D. Smith, M.D.  |             |   | 111 Penn Street   |  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |             | 23b. DATE   | 23c. NAME OF CEMETERY OR CREMATORY                                  |  | 23d. LOCATION CITY OR TOWN  |   | COUNTY  | STATE  |
| Burial   |             | 11/17/80  | King Memorial Cemetery  |  | Baltimore   |   |   | MD   |
| 24. FUNERAL DIRECTOR NAME  |             |   | 25a. DATE REC'D. BY REGISTRAR                                       |  |   | 25b. REGISTRAR'S SIGNATURE  |   |  |
| WILLIAM C. MARCH FUNERAL HOME INC.   |             |   | NOV 12 1980   |  |   |  |   |  |

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD, 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH-17  
(VR A15 ME (5))  
15M 7/76

2000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 0 2 4

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>MILTON CLIFTON EVANS</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 26 80</b> |   | 2b. HOUR<br><b>10:55</b> <sup>M</sup> <sup>P</sup> |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 30 22</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>58</b> YRS.<br>IF UNDER 1 YEAR: MONTHS DAYS<br>IF UNDER 24 HRS: HOURS MIN.           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE, CITY</b> MD  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VAMC, 3900 LOCH RAVEN BLVD. 21218</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SALES</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>MILTON C. EVANS</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>HELEN FOULKE</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>YES</b> (IF YES, GIVE WAR OR DATES) <b>WWII</b>                                     |  |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>219 16 5193</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>EILEEN B. EVANS 5641 PURDUE AVE. 21239</b>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY ARREST</b><br><b>5715</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>UPPER GASTROINTESTINAL Hemorrhage</b> 48 hr<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>Cirrhosis</b> YEARS<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>None</b> |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 min</b> |
| 19a. DATE OF OPERATION<br><b>11-26-80</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>GASTROINTESTINAL Hemorrhage</b>  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from <b>11-10</b> , 19 <b>80</b> , to <b>11-26</b> , 19 <b>80</b> , that (we) last saw the deceased alive on <b>11-26</b> , 19 <b>80</b> , and that in (x) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did not) view the body after death.  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>A. Michael Borkon MD</b>  |  | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>11-27-80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>A. MICHAEL BORKON</b>  |  |   |  | 22e. ADDRESS<br><b>LOCH RAVEN VA HOSPITAL</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>DEC. 1, 1980</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GARDEN OF FAITH CEM.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MD.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>MITCHELL-WIEDEFELD HOME 6500 YORK RD. 21212</b>   |  |   |  | 25a. DATE REC'D BY REGISTRAR<br><b>DEC 2 1980</b>   |  |  |  |





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 0 2 5

REG. NO.

|   |   |   |   |  |  |
|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>WALKER</b> (NMN) <b>EVANS</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11-29-80</b>                            |  | 2b. HOUR<br>MIN.<br><b>10:00 AM</b>  |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>BLACK</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11-3-13</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67 YEARS</b>                             | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>IF UNDER 24 HRS.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>SOUTH CAROLINA</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. <b>BALTIMORE CITY OR COUNTY OF DEATH</b><br><b>CITY</b> MD.                 |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GREATER BALTIMORE MED. CENTER</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>DRIVER</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br><b>MARYLAND</b>   |   |   | 13b. COUNTY<br><b>BALTIMORE</b>   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JAMES EVANS</b>  |   | 15. MOTHER'S MAIDEN NAME<br>MIDDLE LAST<br><b>LESSIE ROBINSON</b>   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>218-10-4397</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>MARGARET EVANS 3100 MONDAWMIN AVE.</b>          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b><br><b>4151</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>MASSIVE PULMONARY EMBOLISM</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <b>11-5-80--</b><br><b>11-29-80</b> |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>CARDIO VASCULAR ACCIDENT</b>   |   |   |   |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>11-5-80</b> , 19____, to <b>11-29-80</b> , 19____, that <input checked="" type="checkbox"/> (we) lost<br>saw the deceased <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.   |   |   |   |  |  |
| 22b. SIGNATURE<br><b>Mohammed Tabbac</b>  |   |   |   | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Mohammed Tabbac, MD</b>   |   |   |   | 22e. ADDRESS   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |   | 23b. DATE<br><b>12-3-80</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ARBUTUS MEM. PK.</b>                  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>   |   | 23e. DATE REC'D. BY REGISTRAR<br><b>DEC 1 1980</b>  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>ELIZABETH L. PHILLIPS</b>  |   | ADDRESS<br><b>1721 N. MONROE ST.</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Patricia K. Brady</b>                         |  |



Handwritten text at the bottom left corner, possibly a signature or initials.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

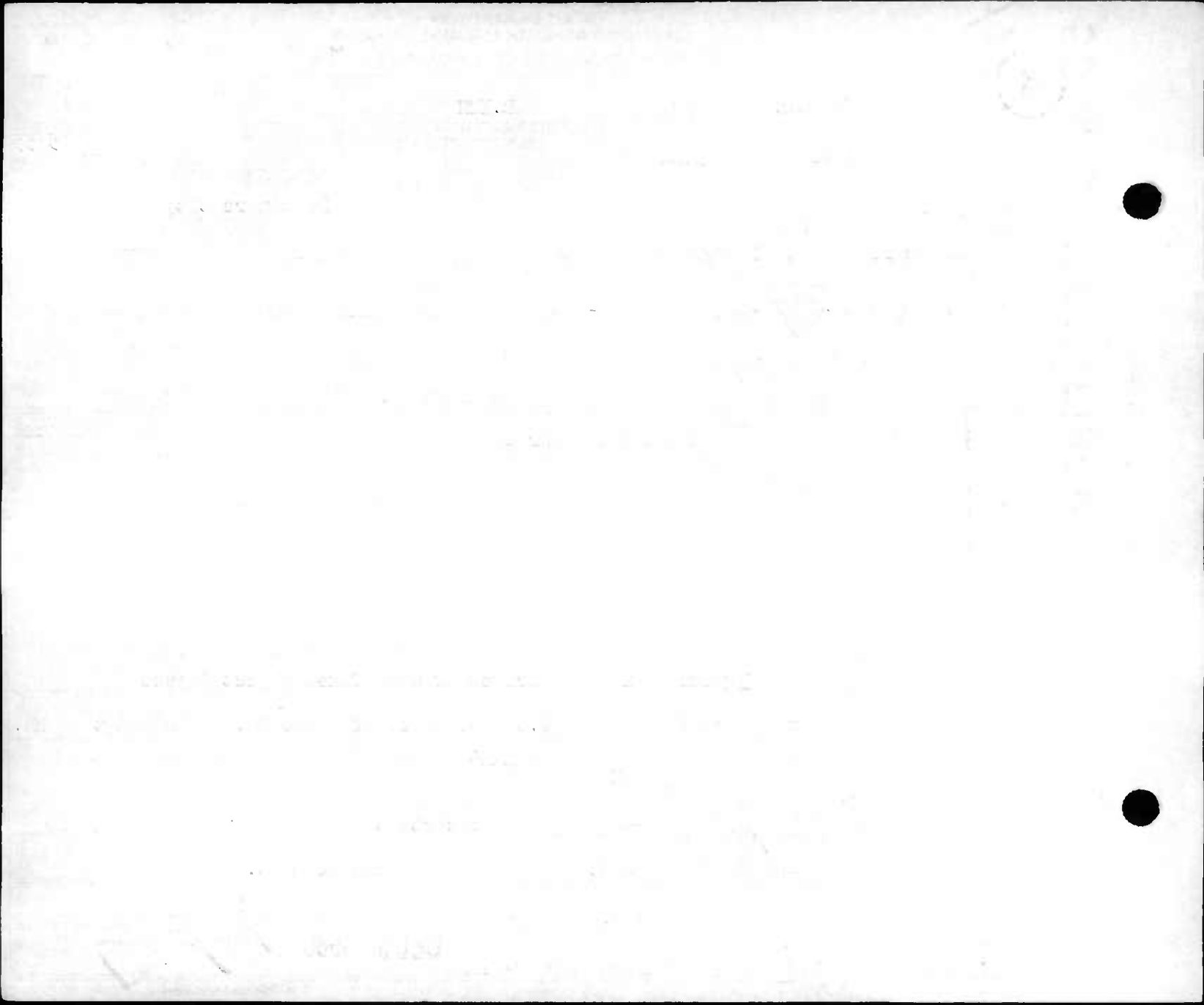
DHMH - 17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

|  |                           |   |   |   |  |   |  |
|--|---------------------------|---|---|---|--|---|--|
| DECEASED NAME<br>(TYPE OR PRINT)   |                           | FIRST<br>NORMAN   | MIDDLE<br>Dewain                              | LAST<br>FAITH   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>MONTH DAY YEAR<br><input checked="" type="checkbox"/> 11 27 1980 |   | 2b. HOUR<br>M<br>P<br>5:55                   |
| 3. SEX<br>male   | 4. RACE<br>white          | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10-12-1950  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>30 YRS. | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | IF UNDER 24 HRS.   | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>11 27 1980                            | 7d. HOUR<br>M<br>P                           |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>W. Va.  |                           | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                          |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |                           | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University Hospital |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Foreman                                 |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Mfg.    |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |                           |   |   | 13a. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br>239 W. Lincoln Ave.  |  |
| 13a. STATE<br>Maryland   | 13b. COUNTY<br>Washington | 13c. CITY OR TOWN<br>Hagerstown   |   |   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Norman E. Faith  |                           | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Violet Virginia Flowers  |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>Yes   |                           | 16b. SOCIAL SECURITY NO.<br>Vietnam   |   | 17. INFORMANT ADDRESS<br>Deborah K. Faith same as deceased  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY: Multiple injuries<br>IMMEDIATE CAUSE (a) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |                           |   |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |                           |   |   |   |  |   |  |
| 19a. DATE OF OPERATION   |                           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                           | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>3:52 PM 11-27-1980   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>Driver of auto/fixed object impact.  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK  |                           | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>road   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>U.S. Rt. 40 e. of Ridge Rd. Washington Md.   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                           |   |   |   |  |   |  |
| ACTUAL SIGNATURE   |                           | TITLE (SPECIFY)<br>Assistant  |   | MEDICAL EXAMINER  |  | DATE SIGNED 11-28-80  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |                           | Ann M. Dixon, M.D.  |   | ADDRESS   |  | 111 Penn St.  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |                           | 23b. DATE<br>12-1-80  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>St. Pauls Lutheran  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Hancock Washington Maryland           |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS   |                           | Richard D. Lane Hancock MD.   |   | 25a. DATE REC'D. BY REGISTRAR<br>DEC 3 1980   |  | 25b. REGISTRAR'S SIGNATURE  |  |



DIVISION OF VITAL RECORDS, 201 W. BALTIMORE ST., BALTIMORE, MARYLAND 21201

404 LOUISE FALKENSTEIN

0389

0201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

4

0389

33

35

300

1

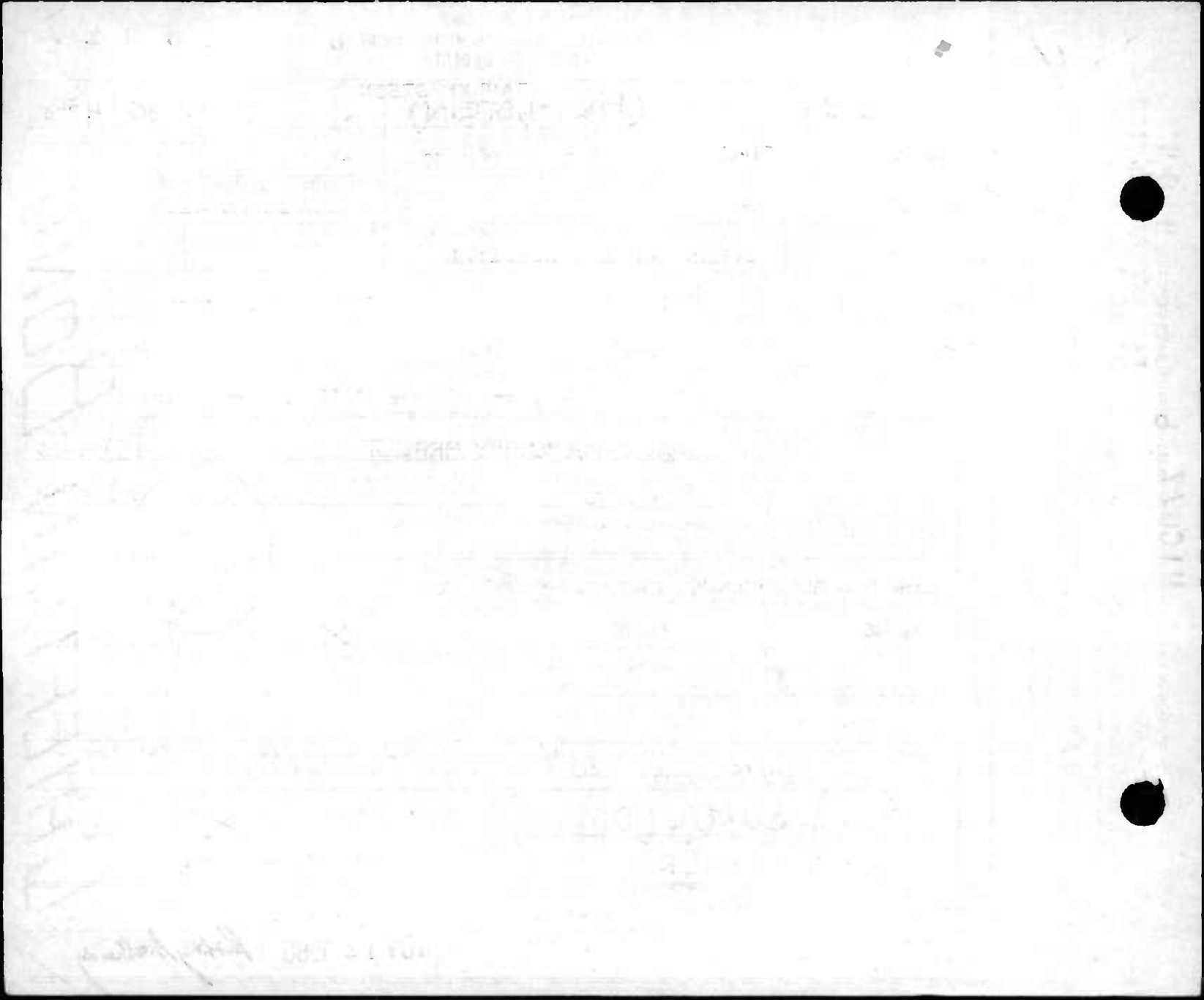
2

1

1

BP

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |                            |  | 8028027         |     |           |          |  |
|---|--|--|--|--|--|---|--|----------------------------|--|-----------------|-----|-----------|----------|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO.   |  |  |  |   |  |                            |  |                 |     |           |          |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST  |  | MIDDLE   |  | LAST  |  | DATE OF DEATH              |  | MONTH           | DAY | YEAR      | 2b. HOUR |  |
| LOUISE  |  |  |  |  |  | FALKENSTEIN   |  | 11                         |  | 10              | 80  | 4:30 A.M. |          |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR            |  | IF UNDER 24 HRS |     |           |          |  |
| Female  |  | Black  |  | 7 MONTH 25 DAY 39 YEAR   |  | 41  |  | YRS.                       |  | MONTHS          |     | DAYS      |          |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                            |  |                 |     |           |          |  |
| Maryland  |  | USA  |  |  |  | BALTIMORE CITY  |  |                            |  |                 |     | MD.       |          |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                            |  |                 |     |           |          |  |
| Baltimore   |  | JOHNS HOPKINS HOSPITAL   |  |  |  |   |  |                            |  |                 |     |           |          |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13b. STATE   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS        |  |                 |     |           |          |  |
| Maryland  |  | Baltimore  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 1933 Eastern Avenue   |  |                            |  |                 |     |           |          |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |   |  |                            |  |                 |     |           |          |  |
| FIRST MIDDLE LAST   |  | FIRST MIDDLE LAST  |  |  |  |   |  |                            |  |                 |     |           |          |  |
| Woodrow   |  | Harding  |  | Alton  |  | Ritz  |  |                            |  |                 |     |           |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS   |  |                            |  |                 |     |           |          |  |
| (IF YES, GIVE WAR OR DATES)   |  | 217-34-8586  |  | Jesse Bibbens  |  | 1037 N. Durham Street   |  |                            |  |                 |     |           |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIO-PULMONARY ARREST</u><br><u>0389</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>SEPSIS</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>45 MINUTES</u><br><u>6 1/2 HOURS</u> |  |  |  |  |  |   |  |                            |  |                 |     |           |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>CHRONIC ALCOHOLISM, CHRONIC PANCREATITIS</u>   |  |  |  |  |  |   |  |                            |  |                 |     |           |          |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |                            |  |                 |     |           |          |  |
| NONE  |  | NONE   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                            |  |                 |     |           |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |                            |  |                 |     |           |          |  |
|   |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |   |  |                            |  |                 |     |           |          |  |
|   |  | P.M. 19  |  |  |  |   |  |                            |  |                 |     |           |          |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION  |  | CITY OR TOWN  |  | COUNTY                     |  | STATE           |     |           |          |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  |  |  |   |  |                            |  |                 |     |           |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/1</u> 19 <u>80</u> , to <u>11/10</u> 19 <u>80</u> , that (I) (we) lost<br>saw the deceased alive on <u>11/10</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |   |  |                            |  |                 |     |           |          |  |
| 22b. SIGNATURE  |  | DEGREE   |  | 22c. DATE SIGNED   |  |   |  |                            |  |                 |     |           |          |  |
| <u>Eric J. Seifter MD</u>   |  |  |  | <u>11/10/80</u>  |  |   |  |                            |  |                 |     |           |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |  |  |   |  |                            |  |                 |     |           |          |  |
| ERIC J. SEIFTER   |  | JOHNS HOPKINS HOSPITAL   |  |  |  |   |  |                            |  |                 |     |           |          |  |
| 23a. BURIAL, CREMATION, REMOVAL   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  | CITY OR TOWN               |  | COUNTY          |     | STATE     |          |  |
| Burial  |  | 11/14/80   |  | Baltimore Cemetery   |  | Baltimore   |  |                            |  |                 |     | MD.       |          |  |
| 24. FUNERAL DIRECTOR  |  | NAME   |  | ADDRESS  |  | DATE RECEIVED BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE |  |                 |     |           |          |  |
| WILLIAM C. MARCH FUNERAL HOME INC.  |  | 1101 E. North Ave.   |  |  |  | NOV 12 1980   |  | <u>Robert McBrady</u>      |  |                 |     |           |          |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

M

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 0 2 8

REG. NO.

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MILDRED VIRGINIA FARINHOLT</b>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>11/1/80</b>  |  | 2b. HOUR<br><b>7:30PM</b>  |  |
| 3. SEX<br><b>female</b>   |  | 4. RACE<br><b>white</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>November 7, 1895</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST AGNES HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>housewife</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>own home</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Arbutus</b>  |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>4418 John Avenue</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Hamp Harrison</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Annie Grimes</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>214-74-6560</b>   |  | 17. INFORMANT ADDRESS<br><b>Mrs. Dortha Meile 4418 John Ave. 21227</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4149</b> IMMEDIATE CAUSE (a) <b>CHF (Congestive Heart Failure)</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CORONARY Artery disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Victor Jaworsky M.D.</b>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>11/1/80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>VICTOR JAWORSKY, M.D.</b>   |  |   |  | 22e. ADDRESS<br><b>900 CATON AVE BALTIMORE MD 21229</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>11/5/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore City Maryland</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Ambrose Funeral Home 1328 Sulphur Spring Rd.</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 3-1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Barney Kibbey</b>   |  |

MEDICAL CERTIFICATION

2  
9

1

4304

BP

DHMH-16 30M 2/80  
(VRA 15, 4)



BALTIMORE CITY

AT JAMES HOSPITAL

BALTIMORE

11-19-1917

11-19-1917

11-19-1917

11-19-1917

11-19-1917

11-19-1917

11-19-1917

11-19-1917

11-19-1917

11-19-1917

11-19-1917

11-19-1917



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 0 2 9

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. FOR STATE REGISTRAR   |  | 2a. DATE OF DEATH   |   | 2b. HOUR   |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | 2a. DATE OF DEATH   |   | 2b. HOUR   |  |
| FIRST MIDDLE LAST<br>LEROY Franklin FARLOW   |  | 11 28 80  |   | 2:50 P.M.  |  |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     | IF UNDER 1 YEAR  |  |
| M  | W  | MONTH DAY YEAR<br>8 30 02   | 78 YRS.   | IF UNDER 24 HRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |
| Mesmoreland County   | U.S.A.   |   | Baltimore City MD.  |  |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |
| Baltimore  | Good Samaritan Hosp.   |   | Farmer  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   | 13b. COUNTY  | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS  |  |
| 13a. State Md.   | 13b. Carroll   | 13c. Finksburg  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 2740 Barrick Rd.   |  |
| 14. FATHER'S NAME  | 15. MOTHER'S MAIDEN NAME   |   |   |  |  |
| FIRST MIDDLE LAST<br>Pete Andrew Farlow  | FIRST MIDDLE LAST<br>Martha Sherman  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  | 16b. SOCIAL SECURITY NO.   | 17. INFORMANT   |   |  |  |
| No   | 219-10-4194  | Finksburg, Md. 21048<br>Viva Flora Farlow 2740 Barrick Rd.  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |
| PART 1. DEATH WAS CAUSED BY:   |  |   |   |  |  |
| IMMEDIATE CAUSE (a) cardiac arrest   |  |   |   |  | 1 hour   |
| 4140 DUE TO, OR AS A CONSEQUENCE OF  |  |   |   |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |   |   |  | 5 days   |
| DUE TO, OR AS A CONSEQUENCE OF   |  |   |   |  |  |
| (b) congestive heart failure   |  |   |   |  |  |
| (c) arteriosclerotic coronary vascular disease   |  |   |   |  | -  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|  |  |   |   | YES <input type="checkbox"/> NO <input type="checkbox"/>                       | YES <input type="checkbox"/> NO <input type="checkbox"/>       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) |  |
|  |  | HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   |  |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION  |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   |   | STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-24 1980 to 11-28 1980, that (I/we) lost saw the deceased alive on 11-28-1980, and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death. |  |   |   |  |  |
| 22b. SIGNATURE   |  | DEGREE  |   | 22c. DATE SIGNED   |  |
| Richard Nora   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>    |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS  |   |  |  |
| RICHARD NORA   |  | GOOD SAMARITAN HOSPITAL   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE   | 23c. NAME OF CEMETERY OR CREMATORY                                  |  | 23d. LOCATION  |
| Burial   |  | 12-1-80   | Evergreen Memorial Gardens  |  | CITY OR TOWN COUNTY STATE<br>Finksburg Carroll Md.             |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE REC'D. BY REGISTRAR   |   | 25b. REGISTERED PHYSICIAN'S SIGNATURE  |  |
| Thomas D. Fletcher & Son F.H.  |  | DEC 3 1980  |   | [Signature]  |  |
| 24. ADDRESS  |  | 25b. REGISTERED PHYSICIAN'S SIGNATURE   |   |  |  |
| 254 East Main St.<br>Washington, Md. 21157   |  |   |   |  |  |

BP



DEC 8 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

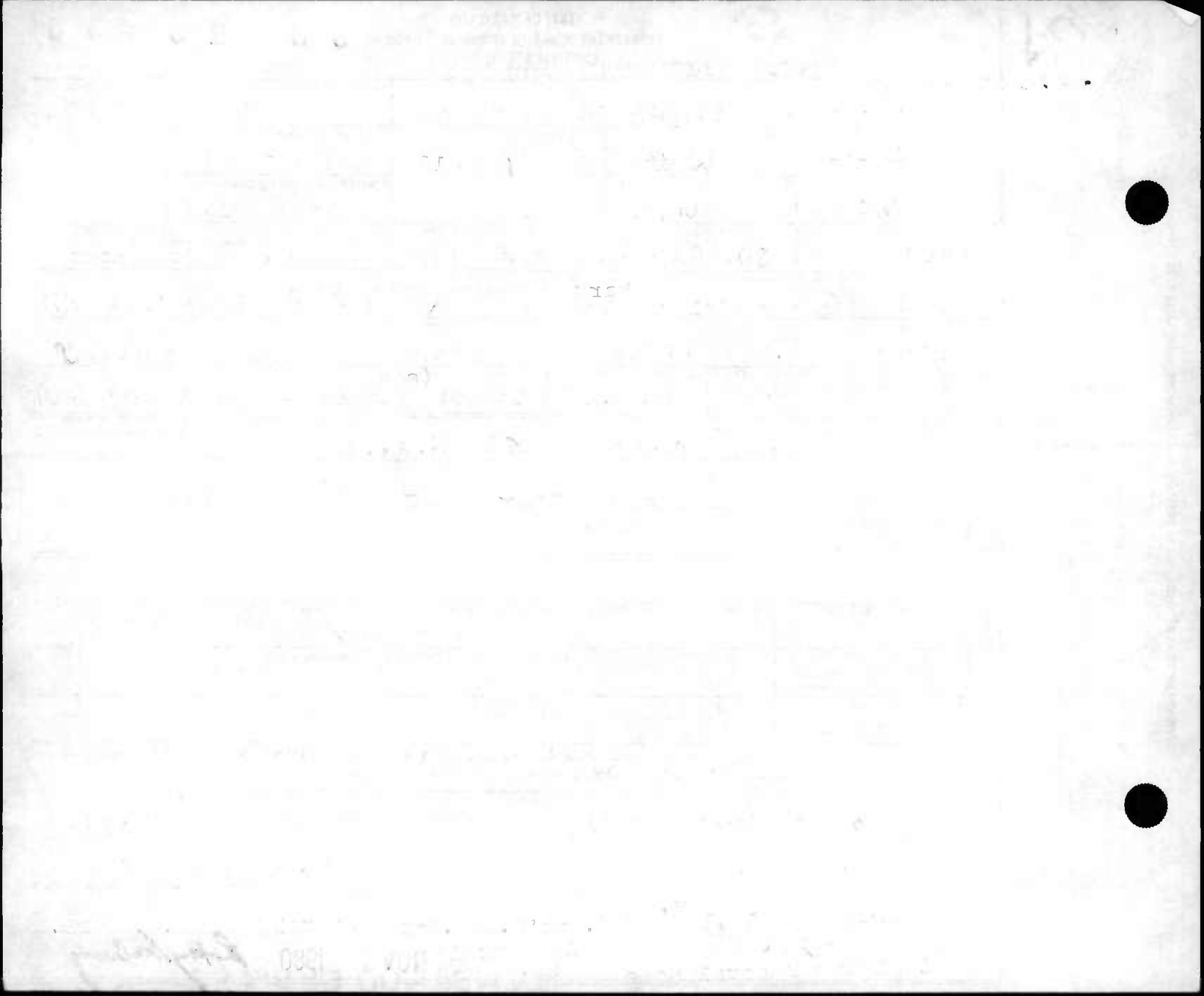
IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 0 2 8 0 3 0  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | BEATRICE ELIZABETH FAULKNER  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR  |  |  |  |
| BEATRICE ELIZABETH FAULKNER   |  |  |  | NOV. 6, 1980 7:45 AM   |  |  |  |
| 3 SEX   |  | 4 RACE   |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |  |
| Female  |  | White  |  | AUG. 1 1913  |  | 67 YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |
| N.C.  |  | U.S.A.   |  |  |  | BALT. CITY MD.   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| BALT.   |  | SS. BALTIMORE GEN. HOSP.   |  | HOUSEWIFE  |  | OWN Home   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  | 13b. INSIDE CITY LIMITS?   |  |  |  |
| 13a. STATE COUNTY   |  |  |  | 13b. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 13a. M.D. Anne Arundel Brooklyn   |  |  |  | 13b. STREET ADDRESS  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |  |
| Lelen PEASE   |  |  |  | ANNIE LOUISE ROLLINS   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT (son) ADDRESS  |  |  |  |
| NO  |  | N/A  |  | 579-09-6073  |  | GEORGE WATSON - 114 W. EDGEVALE                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RESPIRATORY ARREST  |  |  |  |  |  |  |  |
| 1629 DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC CA OF LUNG   |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
|   |  | P.M. 19  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION CITY OR TOWN COUNTY STATE  |  |  |  |
|   |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from NOV. 1, 1980, to NOV. 5, 1980, that (I) (we) last saw the deceased alive on NOV. 5, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE Sol Witriol, M.D.  |  |  |  | DEGREE   |  | 22c. DATE SIGNED   |  |
|   |  |  |  |  |  | 11/5/80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS   |  |  |  |
| SOL WITRIOL, M.D.   |  |  |  | 3301 So. HANOVER ST.   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                        |  |
| Burial  |  | Nov. 10, 1980  |  | Md. Nat'l Mem. Park  |  | Laurel P.G. MD.  |  |
| 24. FUNERAL DIRECTOR NAME   |  | 24b. ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE                                     |  |
| Singleton Funeral Home  |  | Glen Burnie MD.  |  | NOV 7 1980   |  | Rafael M. Brady  |  |

BP \_\_\_\_\_

DHMH-16 25M  
(VRA 15, 4) 1/79



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 0 3 1

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |   |   |                            |  |
|--|--|--|---|---|----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Louis FELD FELD</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 6 80</b> |   | 2b. HOUR<br><b>5:20 AM</b> |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 18 95</b>  |                            |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b>   |  | 7. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                              |   | 8. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto City</b>   |                            |  |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>                             |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sihai Hosp.</b> |                            |  |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>12a. STATE<br><b>MARYLAND</b>  |  | 12b. COUNTY<br><b>BALTIMORE</b>  |   | 12c. CITY OR TOWN<br><b>BALTIMORE</b>   |                            |  |
| 13. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>MORRIS FELD</b>   |  | 14. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>IDA KLEIN</b>      |   | 15. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)<br><b>CLERK</b>   |                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>218 01 0548</b>                         |   | 17. INFORMANT<br><b>MR. JEROME FELD</b>   |                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>4860</b>   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 days</b>          |   |   |                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |   |   |                            |  |
| 19a. DATE OF OPERATION<br><b>---</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>---</b>         |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>           |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>NW 3</b> , 19 <b>80</b> , to <b>NW 6</b> , 19 <b>80</b> , that (I) (we) lost<br>saw the deceased alive on <b>NW 5</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |   |   |                            |  |
| 22b. SIGNATURE<br><b>Steven M. Miller</b>  |  | DEGREE<br><b>M.D.</b>  |   | 22c. DATE SIGNED<br><b>11-6-80</b>  |                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Steven M. Miller M.D.</b>  |  | 22e. ADDRESS<br><b>Sihai Hosp. Balto. Md.</b>                          |   |   |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>   |  | 23b. DATE<br><b>11/7/80</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>TIFERETH ISRAEL</b>  |                            |  |
| 23d. LOCATION<br><b>ROSEDALE</b>   |  | <b>BALTO.</b>  |   | <b>MD</b>   |                            |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>SOL LEVINSON &amp; BROS., INC.</b><br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>   |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 12 1980</b>   |                            |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |  |   |   |                            |  |



FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |   |   |  |  |  |  |  |
|---|--|---|---|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>PEARL  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>NOVEMBER 3, 1980                     |   |  | 2b. HOUR<br>5:30 P.M.  |  |  |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>CAUCASIAN  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>MAY 9, 1907   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>73 YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>PENNSYLVANIA   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY, MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SINAI HOSPITAL |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>AT HOME   |  |  |  |
| 13a. STATE<br>MARYLAND  |  | 13b. COUNTY   |   | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>        |  | 13e. STREET ADDRESS<br>APT. D.<br>6516 PARK HTS. AVE. #21215   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>BORUCH ELLISON  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>FANNIE SALIGMAN            |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO |  |  |  |
| 16b. SOCIAL SECURITY NO<br>212-74-1999  |  |   | 17. INFORMANT<br>MR. ROBERT FELDMAN<br>108-D WALDON RD., ABINGDON, MD 21009 |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <u>A.S.H.D.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>minutes</u><br><u>2 yrs</u> |  |   |   |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><u>Hyperlipidemia</u>   |  |   |   |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                            |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)      |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |  |
| 22a. I certify that (I) (his hospital) attended the deceased from 19 <u>50</u> to <u>present</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>11/3</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Bernard Burgin M.D.</u><br>DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |   |   |   |  | 22c. DATE SIGNED<br><u>11/4/80</u>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>BERNARD BURGIN MD.   |  |   | 22e. ADDRESS<br>3809 CLARKS LANE (21215)                                    |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  |   | 23b. DATE<br>11/6/80  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>CHIZUK AMUNO                             |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MARYLAND |  |  |
| 24. FUNERAL DIRECTOR<br>NAME SOL LEVINSON & BROS., INC.<br>6010 REISTERSTOWN RD. BALTO., MD 21215   |  |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 12 1980                                |   | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                               |  |  |  |  |

1000

1000

1000

1000

1000



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 0 3 3

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |  |   |  |  |  |
|---|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Charles</b>   |  | FIRST<br><b>Fellman</b>  |  | LAST  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 22, 1980</b>   |  | 2b. HOUR<br>M<br><b>M</b>  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Negro</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 3 03</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b>  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>440 E. 22nd. St.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                 |  | 13e. STREET ADDRESS<br><b>440 E. 22nd. St.</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Levi Fell</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Amanda</b>   |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>218-03-7697A</b>  |  | 17. INFORMANT ADDRESS<br><b>A Loring Gordon 440 E. 22nd. St.</b>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>1850</b> IMMEDIATE CAUSE (a) <b>Disseminated Ca Prostate</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 yr</b> |  |  |  |   |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>renal failure aneurysm</b>   |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>9 9</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/21</b> 19 <b>80</b> , to <b>11</b> 19 <b>80</b> , that (I) (we) lost<br>saw the deceased alive on <b>11/21</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Stanley M. Green</b>   |  |  |  | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>11/26/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Pk.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Co. MD</b>  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H 1101 E. North Ave.</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 25 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert M. Kelly</b>  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



NOV 11 1900

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 2 8 0 3 4  
CERTIFICATE OF DEATH

FOR  
1- STATE  
REGISTRAR

REG. NO.

|   |   |   |  |  |  |
|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Elaine Bernadette Fennington</b>                                      |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 23 80</b>                             |  | 2b. HOUR<br><b>230 AM</b>  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>Caucasian</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>April 29, 1947</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>33</b> YRS.                          | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>England</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.          |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore City</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Union Memorial Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Teacher</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>                    |
| 13a. STATE<br><b>Maryland</b>   |   |   | 13b. COUNTY<br><b>-</b>  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                      |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Irving E. Pratt</b>  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Vera A. Mortimer</b>           |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No -</b> |   | 16b. SOCIAL SECURITY NO.<br><b>220-42-6490</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Allen Fennington, husband, same address</b> |  |

|  |  |   |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of the left breast with metastasis</b><br><b>1749</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>to the brain and lung</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>14x</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>14x</b> |
|--|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b)

|   |   |  |   |
|---|---|--|---|
| 19a. DATE OF OPERATION<br><b>5/79</b>   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Radical Mastectomy - CA @ breast</b> | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>                                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>4/14</b> , 19 <b>80</b> , to <b>11/23</b> , 19 <b>80</b> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <b>11/23</b> , 19 <b>80</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (We did/did not) view the body after death. |   |  |   |
| 22a. SIGNATURE<br><b>James C. Farrell</b>   |   | DEGREE<br><b>MD</b>  | 22c. DATE SIGNED<br><b>11/23/80</b>   |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>James C. Farrell, M.D.</b>  |   | 22d. ADDRESS<br><b>Union Memorial Hosp. Balt. MD 21218</b>                     |   |

|   |                              |   |   |
|---|------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b> | 23b. DATE<br><b>11/25/80</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b> |
| 24. FUNERAL DIRECTOR<br><b>Schumnek Funeral Home, Inc.</b>    |                              | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 25 1980</b>           | 25b. REGISTRAR'S SIGNATURE<br><b>Ruthy K. Kelly</b>                 |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Washington

Washington City

United States Capitol

United States Capitol

James C. Parrell, D.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

DHHM-16 25M  
(VRA 15, 4) 1/79

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR   |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 80 28035  |  |   |  |
|--|--|---|--|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>DAVID FERGUSON</b>   |  |   |  | 2. DATE OF DEATH MONTH <b>11</b> DAY <b>14</b> YEAR <b>1980</b>   |  |  |  | 2b. HOUR <b>9 30</b> <b>A</b> M  |  |   |  |
| 3. SEX <b>m</b>  |  | 4. RACE <b>B</b>  |  | 5. DATE OF BIRTH MONTH <b>5</b> DAY <b>5</b> YEAR <b>1925</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>55</b> YRS  |  | 7. UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>                            |  | 7. UNDER 24 HRS. HOURS <b></b> MIN <b></b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>S.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD                                |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Dist. of Col.</b>           |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Gov't.</b>                        |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>D.C.</b> COUNTY <b>W/A</b>   |  |   |  | 13b. CITY OR TOWN <b>WASHINGTON</b>   |  | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13d. STREET ADDRESS <b>1826 INDEPENDENCE AVE. S.E.</b>                 |  |   |  |
| 14. FATHER'S NAME FIRST <b>Emanuel</b> MIDDLE <b></b> LAST <b>Ferguson</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Sallie</b> MIDDLE <b></b> LAST <b>Ward</b>  |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b> (IF YES, GIVE WAR OR DATES) <b>WWII</b>   |  |   |  | 16b. SOCIAL SECURITY NO. <b>250-24-950</b>  |  | 17. INFORMANT ADDRESS <b>John Ferguson-4922 Quarles St. NE, D.C.</b>                         |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIORESP. ARREST</b>  |  |   |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| 1629 DUE TO, OR AS A CONSEQUENCE OF (b) <b>PNEUMONIA</b>   |  |   |  |   |  |  |  |  |  | 2 DAY'S.  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <b>LUNG CANCER</b>  |  |   |  |   |  |  |  |  |  | 1 YR.   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>11 P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that (1) this hospital attended the deceased from <b>11/13</b> 19 <b>80</b> to <b>11/14</b> 19 <b>80</b> , that (1) (we) <input checked="" type="checkbox"/> saw the deceased alive on <b>11/14</b> 19 <b>80</b> , and that in (my) <input checked="" type="checkbox"/> our opinion death occurred on the date and hour and from the causes stated above, (1) (we) <input checked="" type="checkbox"/> did not view the body after death. |  |   |  |   |  |  |  |  |  |   |  |
| 22b. SIGNATURE <b>Scott D. Friedman</b> MD   |  |   |  | DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |  | 22c. DATE SIGNED <b>11/14/80</b>                                       |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SCOTT D. FRIEDMAN, MD</b>   |  |   |  | 22e. ADDRESS <b>22 S. GREENE ST UNIV. HOSP. BALD, MD</b>  |  |  |  |  |  |   |  |
| 23a. BURIAL CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>   |  |   |  | 23b. DATE <b>11-24-80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>LINCOLN MEM. CEM.</b>                                  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>SUITLAND P.G. MD.</b>       |  |   |  |
| 24. FUNERAL DIRECTOR NAME <b>H.S. Washington &amp; Sons</b> ADDRESS <b>4925 Burroughs Ave. N.E.</b>  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>NOV 28 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>                          |  |   |  |

THE UNIVERSITY OF CHICAGO  
LIBRARY

Chicago, Illinois

Dear Sir:  
I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the matter mentioned therein. The same has been forwarded to the proper authorities for their consideration.

Very truly,  
Yours,  
J. S. VOM

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                      |  |  |  |  |  |  |  | REG. NO. 28036  |  |
|---|--|----------------------|--|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |                      |  |  |  |  |  |  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Douglas Ferguson</b>   |  |                      |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> <b>11 20 1980</b> |  | 2b. HOUR <b>6:20 PM</b>  |  |   |  |
| 3. SEX <b>male</b>  |  | 4. RACE <b>black</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>AUG. 3 1958</b>  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY YRS. <b>22</b>  |  | IF UNDER 1 YR. MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>   |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY? <b>US of A</b>  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>                          |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  |  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1st fl. 2911 W. North Avenue</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>UNEMPLOYED</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE <b>MARYLAND</b>  |  |                      |  | 13b. COUNTY  |  | 13c. CITY OR TOWN <b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS <b>2205 ROSLYN AVENUE</b>                                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>LAWRENCE FERGUSON</b>   |  |                      |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>MYRNA FOWLKES</b>   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>NO</b>   |  |                      |  | 16b. SOCIAL SECURITY NO. <b>?</b>  |  | 17. INFORMANT ADDRESS <b>MRS. MYRNA JOHNSON 2205 ROSLYN AVENUE</b>   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY: <b>Blunt trauma to head and neck</b>   |  |                      |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| IMMEDIATE CAUSE (a) <b>9660</b> DUE TO, OR AS A CONSEQUENCE OF  |  |                      |  |  |  |  |  |  |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.   |  |                      |  |  |  |  |  |  |  |   |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF  |  |                      |  |  |  |  |  |  |  |   |  |
| (c)   |  |                      |  |  |  |  |  |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                      |  |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                      |  | 21b. TIME OF INJURY<br>CLOCK TIME MONTH DAY YEAR <b>6:10 PM 11 20 1980</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>subject stabbed</b>             |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>house</b>   |  | 21f. LOCATION<br>CITY OR TOWN <b>Baltimore</b> COUNTY <b>Maryland</b> STATE                                      |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on <u>Autopsy</u> <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                      |  |  |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE <i>Margarita A. Korell</i>   |  |                      |  | TITLE (SPECIFY) <b>Assistant</b>   |  |  |  | DATE SIGNED <b>11-21-80</b>  |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>  |  |                      |  | ADDRESS <b>111 Penn Street</b>   |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>   |  |                      |  | 23b. DATE <b>11/26/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>WESTVIEW MEM. PARK</b>   |  | 23d. LOCATION<br>CITY OR TOWN <b>CATONSVILLE</b> COUNTY <b>(BALTO)</b> STATE <b>MD.</b>  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>LEWIS T. GWYNN</b>  |  |                      |  | ADDRESS <b>4517 PARK HEIGHTS AVENUE</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>NOV 25 1980</b>   |  | 25b. <i>[Signature]</i>   |  |

X

THE UNITED STATES OF AMERICA

DEPARTMENT OF THE INTERIOR

II

WATER RESOURCES DIVISION

WASHINGTON, D. C. 20240

REPORT OF THE DIRECTOR

1961

ANNUAL REPORT OF THE DIRECTOR

TO THE SECRETARY OF THE INTERIOR

FOR THE YEAR 1961

WATER RESOURCES DIVISION

WASHINGTON, D. C. 20240

11/20/61

1517



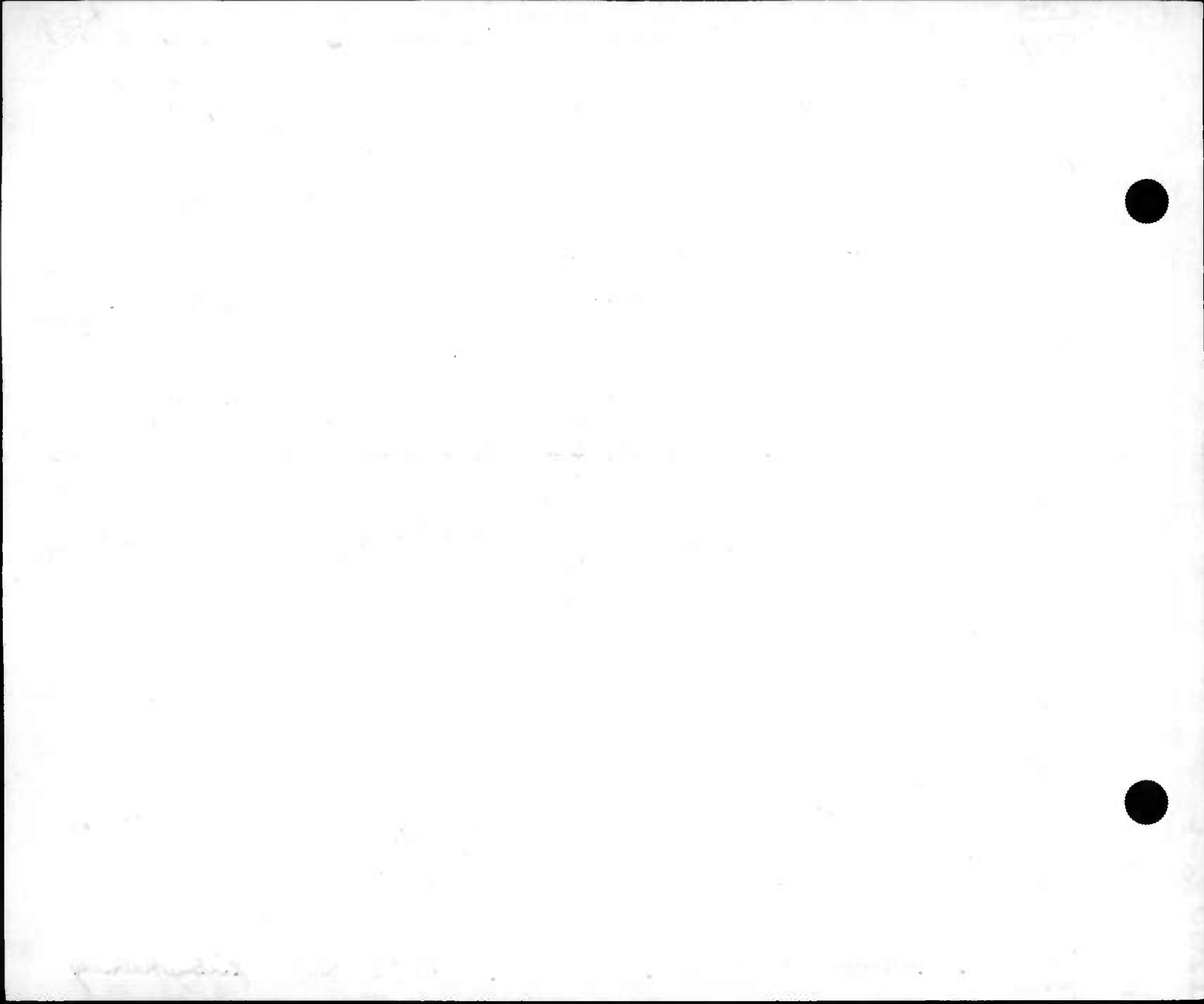
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 0 3 7

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |  |                           |  |
|--|--|---|--|--|---------------------------|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>DOROTHY FIELDS</b>   |  |   | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 30, 1980</b> |  | 2b HOUR<br>M<br><b>AM</b> |  |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>Negro</b>  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 7 08</b>   |                           |  |
| 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b> YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>72</b>   |  | IF UNDER 24 HRS<br>HOURS MIN<br><b>72</b>  |                           |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                           |  |
| 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>   |  | MD  |  |  |                           |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Bon Secour Hospital</b>  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |                           |  |
| 12b KIND OF BUSINESS OR INDUSTRY   |  | 13a STATE<br><b>MD</b>  |  | 13b COUNTY   |                           |  |
| 13c CITY OR TOWN<br><b>Baltimore</b>   |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e STREET ADDRESS<br><b>1917 Edmondson Ave.</b>   |                           |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Louis Harrison</b>   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elsie Waters</b>   |  |  |                           |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b SOCIAL SECURITY NO<br><b>N/A</b>  |  | 17 INFORMANT<br>ADDRESS<br><b>Mary Robins 608 Ashburton Street</b>   |                           |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>4100</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br><b>1000</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Senescent Atherosclerosis</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Years</b><br><b>Years</b> |  |   |  |  |                           |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I   |  |   |  |  |                           |  |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                           |  |
| 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>PM 19</b>   |                           |  |
| 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  | 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                           |  |
| 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  | 22a I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. |  | 22b SIGNATURE<br><b>George VASH</b>  |                           |  |
| 22c DATE SIGNED<br><b>12/1/80</b>  |  | 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>George VASH</b>  |  | 22e ADDRESS<br><b>206 S. Gilmore ST</b>  |                           |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b DATE<br><b>12/4/80</b>  |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Mount Auburn Cemetery</b>  |                           |  |
| 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore MD</b>   |  | 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H 1101 E. North Ave.</b>   |  | 25a DATE REC'D. BY REGISTRAR<br><b>DEC 2 1980</b>  |                           |  |
| 25b REGISTRAR'S SIGNATURE<br><b>Fitzgerald</b>   |  |   |  |  |                           |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 0 3 8

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|   |  |   |  |  |                       |  |  |  |  |                             |  |
|---|--|---|--|--|-----------------------|--|--|--|--|-----------------------------|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>MARION ELIZABETH FIFER       |  |   | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>11 19 80 |  | 2b HOUR<br>A M<br>A M |  |  |  |  |                             |  |
| 3 SEX<br>FEMALE   |  | 4 RACE<br>WHITE   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>05 31 98  |                       | 6 AGE (IN YEARS LAST BIRTHDAY)<br>82 YRS   |  | 7 UNDER 1 YEAR<br>MONTHS DAYS<br>HOURS MIN     |  | 7 UNDER 24 HRS<br>HOURS MIN |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND                                    |  | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                       | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |  |  |  |                             |  |
| 10 CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>623 S. BEECHFIELD AVENUE |  |  |                       | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>UMBRELLA MAKER              |  | 12b KIND OF BUSINESS OR INDUSTRY<br>UMBRELLA   |  |                             |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  |   |  |  |                       |  |  |  |  |                             |  |
| 13a STATE<br>MARYLAND   |  | 13b COUNTY<br>---   |  | 13c CITY OR TOWN<br>BALTIMORE  |                       | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e STREET ADDRESS<br>623 S. BEECHFIELD AVENUE |  |                             |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>CHARLES A. SMITH                               |  |   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MARGARET KATHERINE HEIDLER   |                       |  |  |  |  |                             |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO               |  | 16b SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>212-09-8365  |  | 17 INFORMANT<br>ADDRESS<br>GEORGE H. FIFER, SR. 910 E. PATAPSCO AVE.   |                       |  |  |  |  |                             |  |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute myocardial Infarction  
4100  
DUE TO, OR AS A CONSEQUENCE OF  
(b) Coronary Artery Disease  
DUE TO, OR AS A CONSEQUENCE OF  
(c) \_\_\_\_\_

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |  |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |
| 22b SIGNATURE<br><u>Sang Cheol Do</u> DEGREE _____<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |   |  |   |  | 22c DATE SIGNED<br>11-19-80  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>SANG CHEOL DOH, M.D.   |  |   |  | 22e ADDRESS<br>95 AQUAHART ROAD, GLEN BURNIE  |  |  |  |

|   |  |                      |  |  |  |  |  |
|---|--|----------------------|--|--|--|--|--|
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL     |  | 23b DATE<br>11-22-80 |  | 23c NAME OF CEMETERY OR CREMATORY<br>LORRAINE PARK |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>WOODLAWN BALTIMORE MARYLAND |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>HUBBARD FUNERAL HOME, INC. |  |                      |  | ADDRESS<br>4107 WILKENS AVE.                       |  | 25 DATE REC'D BY REGISTRAR<br>NOV 21 1980                                |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



NOV 1 1960

*Handwritten signature*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

28039

FOR  
STATE  
REGISTRAR

|  |  |   |  |  |                    |  |
|--|--|---|--|--|--------------------|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Ellen J. Fink   |  |   | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>11 18 80 |  | 2b HOUR<br>5:40 PM |  |
| 3 SEX<br>FEMALE  |  | 4 RACE<br>WHITE   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>8-11-1887   |                    |  |
| 6 AGE (IN YEARS LAST BIRTHDAY)<br>93 YRS   |  | 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |                    |  |
| 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |  |                    |  |
| 10 CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>PERRING P.K.W.Y. NURSING H. |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>AT HOME                     |                    |  |
| 12b KIND OF BUSINESS OR INDUSTRY   |  |   |  |  |                    |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br>MD.  |  |   |  |  |                    |  |
| 13b COUNTY<br>BALTO.   |  | 13c CITY OR TOWN<br>PARKVILLE   |  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                    |  |
| 13e STREET ADDRESS<br>8329 Wilson Ave.   |  |   |  |  |                    |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>JAMES DOAKES  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MARGARET McKEWEN  |  |  |                    |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>220547015J1   |  | 17 INFORMANT<br>ADDRESS<br>FAMILY RECORDS  |                    |  |

|   |  |  |  |
|---|--|--|--|
| 11 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) RESPIRATORY FAILURE<br>4860<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) PNEUMONITIS<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>1 DAY<br>2 DAYS |  |
|---|--|--|--|

|   |  |  |  |
|---|--|--|--|
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>ARTERIOSCLEROTIC HEART DISEASE  |  |  |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |
| 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d INJURY OCCURRED<br>AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |
| 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from 5/12, 19 71, to 11/18, 19 80, that (I) (we) lost<br>saw the deceased alive on 11/18, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |
| 22b SIGNATURE<br>Leonard P. Berger MD   |  | 22c DATE SIGNED<br>11/18/80  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>LEONARD P. BERGER MD  |  | 22e ADDRESS<br>8100 HARFORD RD BALTO, MD   |  |

|   |  |                        |  |  |  |   |  |
|---|--|------------------------|--|--|--|---|--|
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL |  | 23b DATE<br>11-22-1980 |  | 23c NAME OF CEMETERY OR CREMATORY<br>NEW CATHEDRAL |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MARYLAND |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>EVANS FUNERAL CHAPEL   |  |                        |  | 24b ADDRESS<br>8800 HARFORD RD.                    |  | 25a DATE REC'D. BY REGISTRAR<br>NOV 20 1980                     |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 2 8 0 4 0  
CERTIFICATE OF DEATH

FOR  
1- STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Paul Finkelstein FINKELSTEIN   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11. 21 80 |   |  | 2b. HOUR<br>4:05 AM  |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>JULY 4, 1912  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>68 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>NEW YORK   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore City   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Union Memorial Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SELF EMPLOYED  |  |
|   |  |  |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>GROCERY   |  |
| 13a. STATE<br>MARYLAND  |  |  |  | 13b. COUNTY<br>BALTIMORE  |  | 13c. CITY OR TOWN<br>BALTIMORE   |  |
| 14. FATHER'S NAME<br>BENJAMIN FINKELSTEIN   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>SARAH LASKA   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WWII ARMY 216-03-7207   |  | 17. INFORMANT<br>ADDRESS<br>MRS. SYLVIA FINKELSTEIN 6230 BERKELEY AVE. #21209   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CAARDIAC ARREST</u><br><u>4275</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>CARDIAC FAILURE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):<br><u>CA of Tongue, Renal insufficiency, AODM</u> |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/10</u> , 19 <u>80</u> , to <u>11/21</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>11/21</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br>Julian Thayer Simmons MD  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br>11/21/80   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JULIAN THAYER SIMMONS  |  |  |  | 22e. ADDRESS<br>UNION MEMORIAL HOSPITAL   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  | 23b. DATE<br>11-23-80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>MISHKON ISRAEL  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO. MD  |  |
| 24. FUNERAL DIRECTOR<br>NAME SOL LEVINSON & BROS., INC.<br>ADDRESS 6010 REISTERSTOWN RD., BALTO., MD 21215  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 25 1980  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

Paul Frankel

Baltimore City

Baltimore City Union Memorial Hospital

NOV 2 1980



1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 0 4 1

REG. NO.

|  |                         |  |   |  |   |
|--|-------------------------|--|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>James Fisher</b>   |                         |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 23, 1980</b>                                 |  | 2b. HOUR<br><b>6:35P</b> M  |
| 1. SEX<br><b>Male</b>  | 4. RACE<br><b>Black</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4/2/19</b>                    |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>61</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>South Carolina</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                          |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |                         | 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                          |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b>                          |   |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |                         | 12b. KIND OF BUSINESS OR INDUSTRY                                      |   |  |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |                         |  |   |  |   |
| 13a. STATE<br><b>Md.</b>   | 13b. COUNTY             | 13c. CITY OR TOWN<br><b>Balto.</b>                                     | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>1701 Eutaw Place</b>   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Wm. W. Fisher</b>   |                         |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Tora Foster</b>                             |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No - Yes</b>  |                         | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>-</b>    |   | 17. INFORMANT<br>ADDRESS<br><b>Willie Fisher 1317 A St. N. W. Wash</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>Bronchopneumonia, Acute</b><br>IMMEDIATE CAUSE (a)<br><b>4960</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Lower Gastrointestinal bleeding from</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>diverticuli of Colon Chronic obstructive lung disease</b>             |                         |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Pulmonary Tuberculosis with foci of bronchiectasis and fibrosis</b>   |                         |  |   |  |   |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>November 23, 19 80</b> , to <b>November 23, 19 80</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>November 23, 19 80</b> , and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (they) did not view the body after death. |                         |  |   |  |   |
| 22b. SIGNATURE<br><b>Joseph Gent M.D.</b>  |                         |  |   | 22c. DATE SIGNED<br><b>11/24/80</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Joseph Gent M.D.</b>   |                         |  |   | 22e. ADDRESS<br><b>Care of Maryland General Hospital</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |                         | 23b. DATE<br><b>11/28/80</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Park</b>   |   |
| 23d. LOCATION<br>CITY OR TOWN<br><b>Randallstown</b>   |                         | COUNTY<br><b>Md.</b>   |   | STATE  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>WM. C. MARCH F/H. 1101 East North Avenue</b>  |                         |  |   | 25. DATE RECEIVED BY REGISTRAR<br><b>NOV 28 1980</b>   |   |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80

28042

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |   |   |   |   |   |  |  |
|--|--|---|---|---|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARGARET FITCH</b>            |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Nov 16 1980</b>               |   |   | 2b. HOUR<br>MIN<br><b>2:35 PM</b>   |   |   |  |  |
| 3. SEX<br><b>F.</b>  |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11/4/1893</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b>  |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.           |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BALTO Md</b>         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. CITY MD</b>   |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO</b>                            |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>HAMILTON Nursing Center</b> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housekeeper</b>                        |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>At Home</b> |  |  |
| 13a. STATE<br><b>Md</b>  |  |   | 13b. COUNTY<br><b>BALTO</b>   |   | 13c. CITY OR TOWN<br><b>POTTY H. LL Ave</b> |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>MATTHEW FITZPATRICK</b> |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARGARET TINNEN</b> |   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b> |   |   | 16b. SOCIAL SECURITY NO.<br><b>216-05-5639</b> |  |
| 17. INFORMANT<br><b>Family</b>                                       |  |   | ADDRESS<br><b>Records</b>   |   |   |   |   |   |  |  |

## 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**4370**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

**years****years****years**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 16</b> , 19 <b>80</b> , to <b>Nov 16</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>Nov 16</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Raymond S. Magno</b>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11/17/80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Raymond S. Magno MD</b>  |  |  |  | 22e. ADDRESS<br><b>7811 Wise Ave</b>  |  |  |  |

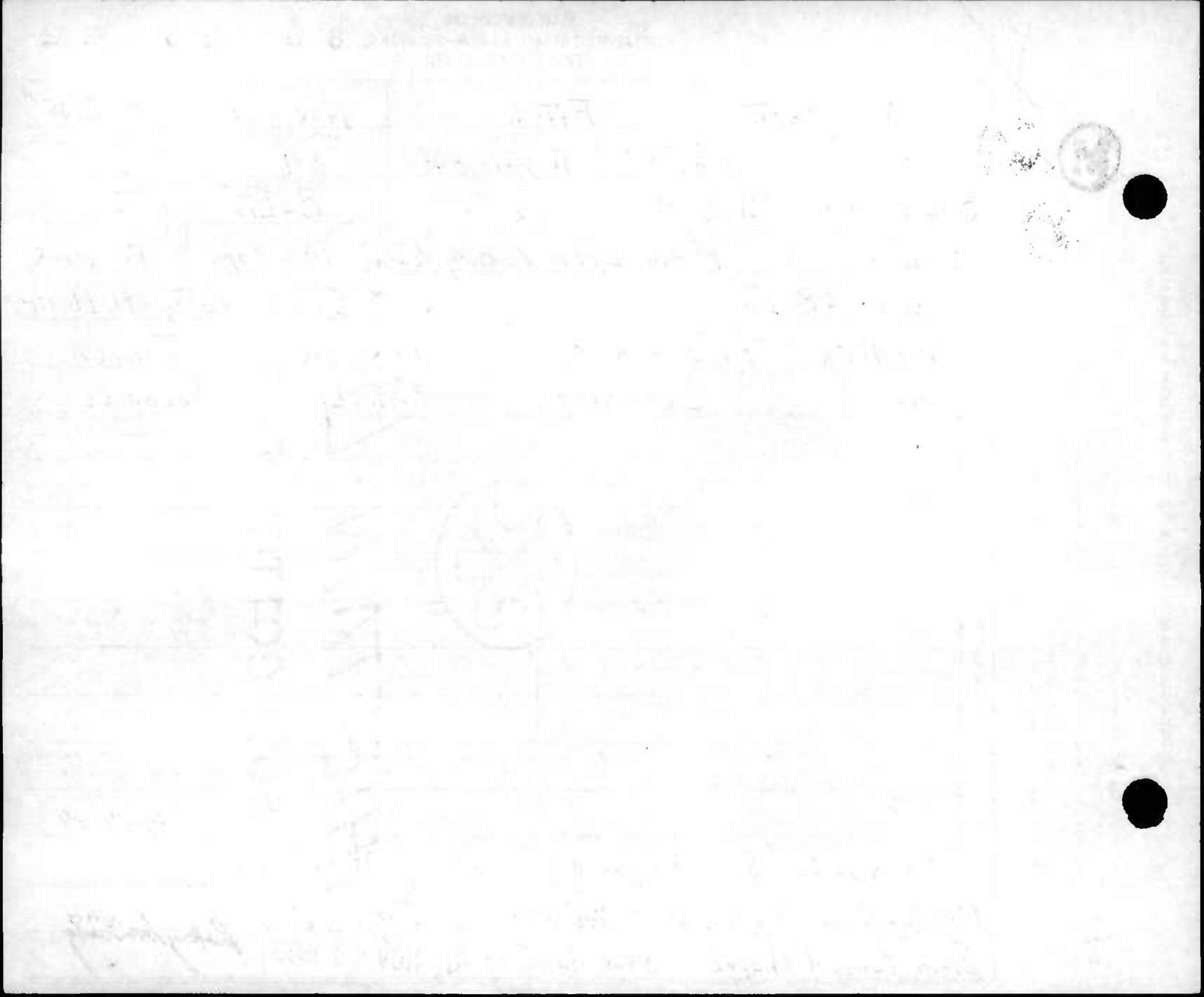
|  |  |                              |  |   |  |   |  |
|--|--|------------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>CREMATION</b> |  | 23b. DATE<br><b>11/17/80</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Crematory</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. BALTO. MD</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>EVANS Funeral Chapel</b>      |  |                              |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 20 1980</b>             |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                      |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 0 4 3

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |  |   |   |
|--|--|--|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Margaret D Fitzgerald  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 6 1980 |   |  | 2b. HOUR<br>6:00 AM   |   |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2 27 1900   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>80<br>YRS MONTHS DAYS  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Long Green Nursing Home |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker   |   |
| 13a. STATE<br>Md.  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John McHale  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Margaret McHale   |  |   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no   |  | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>217 38 3177 B  |  | 17. INFORMANT<br>Mary K. Reilly   |  | ADDRESS<br>407 Dunbarton Rd.  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Sepsis<br>5990<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Probable urinary tract infection<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Senile dementia with generalized debility    |  |  |  |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>36 hrs.<br>48 hrs.<br>6 mos. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).   |  |  |  |   |  |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/13 19 80, to 11/6 19 80, that (II) (we) last saw the deceased alive on 11/5 19 80, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |   |
| 22b. SIGNATURE<br>David D. Collins MD  |  |  |  | DEGREE<br>MD  |  | 22c. DATE SIGNED<br>11/7/80   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>David D. Collins M.D.   |  |  |  | 22e. ADDRESS<br>500 W. University Pkw.  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>11/8/1980   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>New Cathedral Cemetery  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto MD  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Mitchell-Wiedefeld Home  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 12 1980  |  |   |   |
| ADDRESS<br>6500 York Rd.   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |  |   |   |

1000

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

26

27

28

29

30

31

32

33

34

35

36

37

38

39

40

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |   |  | 80 28044   |  |
|---|--|--|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO.   |  |   |  |   |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Ruth M. Fitzberger</b>  |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11/29/80</b>  |  | 2b. HOUR<br><b>10:15<sup>AM</sup></b>   |  | A  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>white</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Mar. 16, 1907</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>10 15</b>   |  | 8. IF UNDER 24 HRS<br>HOURS MIN.<br><b>10 15</b>                               |  |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD                                |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1421 Medfield Avenue</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Technician</b>           |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Catalyst Research</b>   |  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>-</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1421 Medfield Avenue</b>  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Benjamin Wheatley</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Amanda Orem</b>   |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>214 34 3572A</b>   |  | 17. INFORMANT<br><b>Jean Hoover</b>   |  | ADDRESS<br><b>Same</b>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4100 Acute MI</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Myocardial C/P + Arterial Decomp.</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Renal Arteriosclerosis</b> |  |  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b><br><b>3-4 yr</b> |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).<br><b>Diabetes Mellitus, Arteriosclerosis</b>   |  |  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>12-2-80</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Amputation</b>  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>3711 Falls Road Towson, Baltimore Md</b>  |  |   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11-14-80</b> 19 <b>80</b> , to <b>11-29-80</b> 19 <b>80</b> , that (we) lost<br>saw the deceased alive on <b>11-14-80</b> 19 <b>80</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above (b) (we) (did) (did not) view the body after death.                                   |  |  |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Lawrence Shimanek</b>  |  |  |  |   |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>12-2-80</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Lawrence Shimanek</b>   |  |  |  |   |  | 22e. ADDRESS<br><b>3711 Falls Road</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>12/2/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Prospect Hill Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Towson, Baltimore Md</b>                       |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Burgee Funeral Home 3631 Falls Road 21211</b>  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 2 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |

11/22/80

11/22/80

11/22/80



11

11/22/80

11/22/80

11

11/22/80

11/22/80

11/22/80

11/22/80

11/22/80

11/22/80

11/22/80

11/22/80

11

11/22/80

11

11/22/80

11/22/80

11/22/80

11/22/80

11/22/80

11/22/80

11/22/80

11/22/80

11/22/80

11/22/80

11/22/80

11/22/80

11/22/80

11/22/80

11/22/80

11/22/80

11/22/80



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 0 4 5

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |                                       |  |
|---|--|---|--|---|---------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Maurice J. Fitzhugh</i>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>Nov. 21, 1980</i>            |   | 2b. HOUR<br>M<br><i>M</i>             |  |
| 3. SEX<br><i>Male</i>   |  | 4. RACE<br><i>White</i>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>June 13, 1915</i>  |                                       | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><i>65</i>   |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>1437 William St. Balto. Md.</i> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Chauffeur</i>  |                                       | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>B. Greene &amp; Co.</i>  |
| 13a. STATE<br><i>Maryland</i>   |  |   | 13b. COUNTY<br><i>Baltimore</i>  |   | 13c. CITY OR TOWN<br><i>Baltimore</i> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Charles W. Fitzhugh</i>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Ella M. Quinby</i> |   |                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>220-07-5066</i>   |  | 17. INFORMANT<br>ADDRESS<br><i>Mrs. Violet Fitzhugh, Same as above</i>  |                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Pneumonia</i><br>4140<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Congestive Heart Failure</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>Atherosclerotic Heart Disease</i><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>5 days</i><br><i>1 year</i><br><i>10 years</i> |  |   |  |   |                                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><i>Cerebrovascular accident</i>   |  |   |  |   |                                       |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                                       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                       |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <i>7-19-80</i> to <i>11-21-80</i> , that (1) (we) lost saw the deceased alive on <i>11/21/80</i> , and that (1) (our) opinion death occurred on the date and hour and from the causes stated above. (we) did (did not) view the body after death.  |  |   |  |   |                                       |  |
| 22b. SIGNATURE<br><i>Alfred J. Daniels</i>  |  | DEGREE<br><i>MD</i>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |                                       | 22c. DATE SIGNED<br><i>11/24/80</i>  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Alfred J. Daniels, M.D.</i>   |  | 22e. ADDRESS<br><i>510 E. Fort Ave. Balto. Md. 21230</i>  |  |   |                                       |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>  |  | 23b. DATE<br><i>Nov. 25, 1980</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Glen Haven Mem. Park</i>   |                                       | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Glen Burnie, A.A. Co. Maryland</i>  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>McMully Funeral Home, 130 E. Fort Ave. Balto. Md.</i>  |  | ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR<br><i>NOV 25 1980</i>   |                                       | 25b. REGISTRAR'S SIGNATURE<br><i>Patricia Kennedy</i>  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

|      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |        |
|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|--------|
| 1879 | 1880 | 1881 | 1882 | 1883 | 1884 | 1885 | 1886 | 1887 | 1888 | 1889 | 1890 | 1891 | 1892 | 1893 | 1894 | 1895 | 1896 | 1897 | 1898 | 1899 | 1900 | 1901 | 1902 | 1903 | 1904 | 1905 | 1906 | 1907 | 1908 | 1909 | 1910 | 1911 | 1912 | 1913 | 1914 | 1915 | 1916 | 1917 | 1918 | 1919 | 1920 | 1921 | 1922 | 1923 | 1924 | 1925 | 1926 | 1927 | 1928 | 1929 | 1930 | 1931 | 1932 | 1933 | 1934 | 1935 | 1936 | 1937 | 1938 | 1939 | 1940 | 1941 | 1942 | 1943 | 1944 | 1945 | 1946 | 1947 | 1948 | 1949 | 1950 | 1951 | 1952 | 1953 | 1954 | 1955 | 1956 | 1957 | 1958 | 1959 | 1960 | 1961 | 1962 | 1963 | 1964 | 1965 | 1966 | 1967 | 1968 | 1969 | 1970 | 1971 | 1972 | 1973 | 1974 | 1975 | 1976 | 1977 | 1978 | 1979 | 1980 | 1981 | 1982 | 1983 | 1984 | 1985 | 1986 | 1987 | 1988 | 1989 | 1990 | 1991 | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 | 2027 | 2028 | 2029 | 2030 | 2031 | 2032 | 2033 | 2034 | 2035 | 2036 | 2037 | 2038 | 2039 | 2040 | 2041 | 2042 | 2043 | 2044 | 2045 | 2046 | 2047 | 2048 | 2049 | 2050 | 2051 | 2052 | 2053 | 2054 | 2055 | 2056 | 2057 | 2058 | 2059 | 2060 | 2061 | 2062 | 2063 | 2064 | 2065 | 2066 | 2067 | 2068 | 2069 | 2070 | 2071 | 2072 | 2073 | 2074 | 2075 | 2076 | 2077 | 2078 | 2079 | 2080 | 2081 | 2082 | 2083 | 2084 | 2085 | 2086 | 2087 | 2088 | 2089 | 2090 | 2091 | 2092 | 2093 | 2094 | 2095 | 2096 | 2097 | 2098 | 2099 | 2100 | 2101 | 2102 | 2103 | 2104 | 2105 | 2106 | 2107 | 2108 | 2109 | 2110 | 2111 | 2112 | 2113 | 2114 | 2115 | 2116 | 2117 | 2118 | 2119 | 2120 | 2121 | 2122 | 2123 | 2124 | 2125 | 2126 | 2127 | 2128 | 2129 | 2130 | 2131 | 2132 | 2133 | 2134 | 2135 | 2136 | 2137 | 2138 | 2139 | 2140 | 2141 | 2142 | 2143 | 2144 | 2145 | 2146 | 2147 | 2148 | 2149 | 2150 | 2151 | 2152 | 2153 | 2154 | 2155 | 2156 | 2157 | 2158 | 2159 | 2160 | 2161 | 2162 | 2163 | 2164 | 2165 | 2166 | 2167 | 2168 | 2169 | 2170 | 2171 | 2172 | 2173 | 2174 | 2175 | 2176 | 2177 | 2178 | 2179 | 2180 | 2181 | 2182 | 2183 | 2184 | 2185 | 2186 | 2187 | 2188 | 2189 | 2190 | 2191 | 2192 | 2193 | 2194 | 2195 | 2196 | 2197 | 2198 | 2199 | 2200 | 2201 | 2202 | 2203 | 2204 | 2205 | 2206 | 2207 | 2208 | 2209 | 2210 | 2211 | 2212 | 2213 | 2214 | 2215 | 2216 | 2217 | 2218 | 2219 | 2220 | 2221 | 2222 | 2223 | 2224 | 2225 | 2226 | 2227 | 2228 | 2229 | 2230 | 2231 | 2232 | 2233 | 2234 | 2235 | 2236 | 2237 | 2238 | 2239 | 2240 | 2241 | 2242 | 2243 | 2244 | 2245 | 2246 | 2247 | 2248 | 2249 | 2250 | 2251 | 2252 | 2253 | 2254 | 2255 | 2256 | 2257 | 2258 | 2259 | 2260 | 2261 | 2262 | 2263 | 2264 | 2265 | 2266 | 2267 | 2268 | 2269 | 2270 | 2271 | 2272 | 2273 | 2274 | 2275 | 2276 | 2277 | 2278 | 2279 | 2280 | 2281 | 2282 | 2283 | 2284 | 2285 | 2286 | 2287 | 2288 | 2289 | 2290 | 2291 | 2292 | 2293 | 2294 | 2295 | 2296 | 2297 | 2298 | 2299 | 2300 | 2301 | 2302 | 2303 | 2304 | 2305 | 2306 | 2307 | 2308 | 2309 | 2310 | 2311 | 2312 | 2313 | 2314 | 2315 | 2316 | 2317 | 2318 | 2319 | 2320 | 2321 | 2322 | 2323 | 2324 | 2325 | 2326 | 2327 | 2328 | 2329 | 2330 | 2331 | 2332 | 2333 | 2334 | 2335 | 2336 | 2337 | 2338 | 2339 | 2340 | 2341 | 2342 | 2343 | 2344 | 2345 | 2346 | 2347 | 2348 | 2349 | 2350 | 2351 | 2352 | 2353 | 2354 | 2355 | 2356 | 2357 | 2358 | 2359 | 2360 | 2361 | 2362 | 2363 | 2364 | 2365 | 2366 | 2367 | 2368 | 2369 | 2370 | 2371 | 2372 | 2373 | 2374 | 2375 | 2376 | 2377 | 2378 | 2379 | 2380 | 2381 | 2382 | 2383 | 2384 | 2385 | 2386 | 2387 | 2388 | 2389 | 2390 | 2391 | 2392 | 2393 | 2394 | 2395 | 2396 | 2397 | 2398 | 2399 | 2400 | 2401 | 2402 | 2403 | 2404 | 2405 | 2406 | 2407 | 2408 | 2409 | 2410 | 2411 | 2412 | 2413 | 2414 | 2415 | 2416 | 2417 | 2418 | 2419 | 2420 | 2421 | 2422 | 2423 | 2424 | 2425 | 2426 | 2427 | 2428 | 2429 | 2430 | 2431 | 2432 | 2433 | 2434 | 2435 | 2436 | 2437 | 2438 | 2439 | 2440 | 2441 | 2442 | 2443 | 2444 | 2445 | 2446 | 2447 | 2448 | 2449 | 2450 | 2451 | 2452 | 2453 | 2454 | 2455 | 2456 | 2457 | 2458 | 2459 | 2460 | 2461 | 2462 | 2463 | 2464 | 2465 | 2466 | 2467 | 2468 | 2469 | 2470 | 2471 | 2472 | 2473 | 2474 | 2475 | 2476 | 2477 | 2478 | 2479 | 2480 | 2481 | 2482 | 2483 | 2484 | 2485 | 2486 | 2487 | 2488 | 2489 | 2490 | 2491 | 2492 | 2493 | 2494 | 2495 | 2496 | 2497 | 2498 | 2499 | 2500 | 2501 | 2502 | 2503 | 2504 | 2505 | 2506 | 2507 | 2508 | 2509 | 2510 | 2511 | 2512 | 2513 | 2514 | 2515 | 2516 | 2517 | 2518 | 2519 | 2520 | 2521 | 2522 | 2523 | 2524 | 2525 | 2526 | 2527 | 2528 | 2529 | 2530 | 2531 | 2532 | 2533 | 2534 | 2535 | 2536 | 2537 | 2538 | 2539 | 2540 | 2541 | 2542 | 2543 | 2544 | 2545 | 2546 | 2547 | 2548 | 2549 | 2550 | 2551 | 2552 | 2553 | 2554 | 2555 | 2556 | 2557 | 2558 | 2559 | 2560 | 2561 | 2562 | 2563 | 2564 | 2565 | 2566 | 2567 | 2568 | 2569 | 2570 | 2571 | 2572 | 2573 | 2574 | 2575 | 2576 | 2577 | 2578 | 2579 | 2580 | 2581 | 2582 | 2583 | 2584 | 2585 | 2586 | 2587 | 2588 | 2589 | 2590 | 2591 | 2592 | 2593 | 2594 | 2595 | 2596 | 2597 | 2598 | 2599 | 2600 | 2601 | 2602 | 2603 | 2604 | 2605 | 2606 | 2607 | 2608 | 2609 | 2610 | 2611 | 2612 | 2613 | 2614 | 2615 | 2616 | 2617 | 2618 | 2619 | 2620 | 2621 | 2622 | 2623 | 2624 | 2625 | 2626 | 2627 | 2628 | 2629 | 2630 | 2631 | 2632 | 2633 | 2634 | 2635 | 2636 | 2637 | 2638 | 2639 | 2640 | 2641 | 2642 | 2643 | 2644 | 2645 | 2646 | 2647 | 2648 | 2649 | 2650 | 2651 | 2652 | 2653 | 2654 | 2655 | 2656 | 2657 | 2658 | 2659 | 2660 | 2661 | 2662 | 2663 | 2664 | 2665 | 2666 | 2667 | 2668 | 2669 | 2670 | 2671 | 2672 | 2673 | 2674 | 2675 | 2676 | 2677 | 2678 | 2679 | 2680 | 2681 | 2682 | 2683 | 2684 | 2685 | 2686 | 2687 | 2688 | 2689 | 2690 | 2691 | 2692 | 2693 | 2694 | 2695 | 2696 | 2697 | 2698 | 2699 | 2700 | 2701 | 2702 | 2703 | 2704 | 2705 | 2706 | 2707 | 2708 | 2709 | 2710 | 2711 | 2712 | 2713 | 2714 | 2715 | 2716 | 2717 | 2718 | 2719 | 2720 | 2721 | 2722 | 2723 | 2724 | 2725 | 2726 | 2727 | 2728 | 2729 | 2730 | 2731 | 2732 | 2733 | 2734 | 2735 | 2736 | 2737 | 2738 | 2739 | 2740 | 2741 | 2742 | 2743 | 2744 | 2745 | 2746 | 2747 | 2748 | 2749 | 2750 | 2751 | 2752 | 2753 | 2754 | 2755 | 2756 | 2757 | 2758 | 2759 | 2760 | 2761 | 2762 | 2763 | 2764 | 2765 | 2766 | 2767 | 2768 | 2769 | 2770 | 2771 | 2772 | 2773 | 2774 | 2775 | 2776 | 2777 | 2778 | 2779 | 2780 | 2781 | 2782 | 2783 | 2784 | 2785 | 2786 | 2787 | 2788 | 2789 | 2790 | 2791 | 2792 | 2793 | 2794 | 2795 | 2796 | 2797 | 2798 | 2799 | 2800 | 2801 | 2802 | 2803 | 2804 | 2805 | 2806 | 2807 | 2808 | 2809 | 2810 | 2811 | 2812 | 2813 | 2814 | 2815 | 2816 | 2817 | 2818 | 2819 | 2820 | 2821 | 2822 | 2823 | 2824 | 2825 | 2826 | 2827 | 2828 | 2829 | 2830 | 2831 | 2832 | 2833 | 2834 | 2835 | 2836 | 2837 | 2838 | 2839 | 2840 | 2841 | 2842 | 2843 | 2844 | 2845 | 2846 | 2847 | 2848 | 2849 | 2850 | 2851 | 2852 | 2853 | 2854 | 2855 | 2856 | 2857 | 2858 | 2859 | 2860 | 2861 | 2862 | 2863 | 2864 | 2865 | 2866 | 2867 | 2868 | 2869 | 2870 | 2871 | 2872 | 2873 | 2874 | 2875 | 2876 | 2877 | 2878 | 2879 | 2880 | 2881 | 2882 | 2883 | 2884 | 2885 | 2886 | 2887 | 2888 | 2889 | 2890 | 2891 | 2892 | 2893 | 2894 | 2895 | 2896 | 2897 | 2898 | 2899 | 2900 | 2901 | 2902 | 2903 | 2904 | 2905 | 2906 | 2907 | 2908 | 2909 | 2910 | 2911 | 2912 | 2913 | 2914 | 2915 | 2916 | 2917 | 2918 | 2919 | 2920 | 2921 | 2922 | 2923 | 2924 | 2925 | 2926 | 2927 | 2928 | 2929 | 2930 | 2931 | 2932 | 2933 | 2934 | 2935 | 2936 | 2937 | 2938 | 2939 | 2940 | 2941 | 2942 | 2943 | 2944 | 2945 | 2946 | 2947 | 2948 | 2949 | 2950 | 2951 | 2952 | 2953 | 2954 | 2955 | 2956 | 2957 | 2958 | 2959 | 2960 | 2961 | 2962 | 2963 | 2964 | 2965 | 2966 | 2967 | 2968 | 2969 | 2970 | 2971 | 2972 | 2973 | 2974 | 2975 | 2976 | 2977 | 2978 | 2979 | 2980 | 2981 | 2982 | 2983 | 2984 | 2985 | 2986 | 2987 | 2988 | 2989 | 2990 | 2991 | 2992 | 2993 | 2994 | 2995 | 2996 | 2997 | 2998 | 2999 | 3000 | 3001 | 3002 | 3003 | 3004 | 3005 | 3006 | 3007 | 3008 | 3009 | 3010 | 3011 | 3012 | 3013 | 3014 | 3015 | 3016 | 3017 | 3018 | 3019 | 3020 | 3021 | 3022 | 3023 | 3024 | 3025 | 3026 | 3027 | 3028 | 3029 | 3030 | 3031 | 3032 | 3033 | 3034 | 3035 | 3036 | 3037 | 3038 | 3039 | 3040 | 3041 | 3042 | 3043 | 3044 | 3045 | 3046 | 3047 | 3048 | 3049 | 3050 | 3051 | 3052 | 3053 | 3054 | 3055 | 3056 | 3057 | 3058 | 3059 | 3060 | 3061 | 3062 | 3063 | 3064 | 3065 | 3066 | 3067 | 3068 | 3069 | 3070 | 3071 | 3072 | 3073 | 3074 | 3075 | 3076 | 3077 | 3078 | 3079 | 3080 | 3081 | 3082 | 3083 | 3084 | 3085 | 3086 | 3087 | 3088 | 3089 | 3090 | 3091 | 3092 | 3093 | 3094 | 3095 | 3096 | 3097 | 3098 | 3099 | 3100 | 3101 | 3102 | 3103 | 3104 | 3105 | 3106 | 3107 | 3108 | 3109 | 3110 | 3111 | 3112 | 3113 | 3114 | 3115 | 3116 | 3117 | 3118 | 3119 | 3120 | 3121 | 3122 | 3123 | 3124 | 3125 | 3126 | 3127 | 3128 | 3129 | 3130 | 3131 | 3132 | 3133 | 3134 | 3135 | 3136 | 3137 | 3138 | 3139 | 3140 | 3141 | 3142 | 3143 | 3144 | 3145 | 3146 | 3147 | 3148 | 3149 | 3150 | 3151 | 3152 | 3153 | 3154 | 3155 | 3156 | 3157 | 3158 | 3159 | 3160 | 3161 | 3162 | 3163 | 3164 | 3165 | 3166 | 3167 | 3168 | 3169 | 3170 | 3171 | 3172 | 3173 | 3174 | 3175 | 3176 | 3177 | 3178 | 3179 | 3180 | 3181 | 3182 | 3183 | 3184 | 3185 | 3186 | 3187 | 3188 | 3189 | 3190 | 3191 | 3192 | 3193 | 3194 | 3195 | 3196 | 3197 | 3198 | 3199 | 3200 | 3201 | 3202 | 3203 | 3204 | 3205 | 3206 | 3207 | 3208 | 3209 | 3210 | 3211 | 3212 | 3213 | 3214 | 3215 | 3216 | 3217 | 3218 | 3219 | 3220 | 3221 | 3222 | 3223 | 3224 | 3225 | 3226 | 3227 | 3228 | 3229 | 3230 | 3231 | 3232 | 3233 | 3234 | 3235 | 3236 | 3237 | 3238 | 3239 | 3240 | 3241</ |
|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|--------|

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

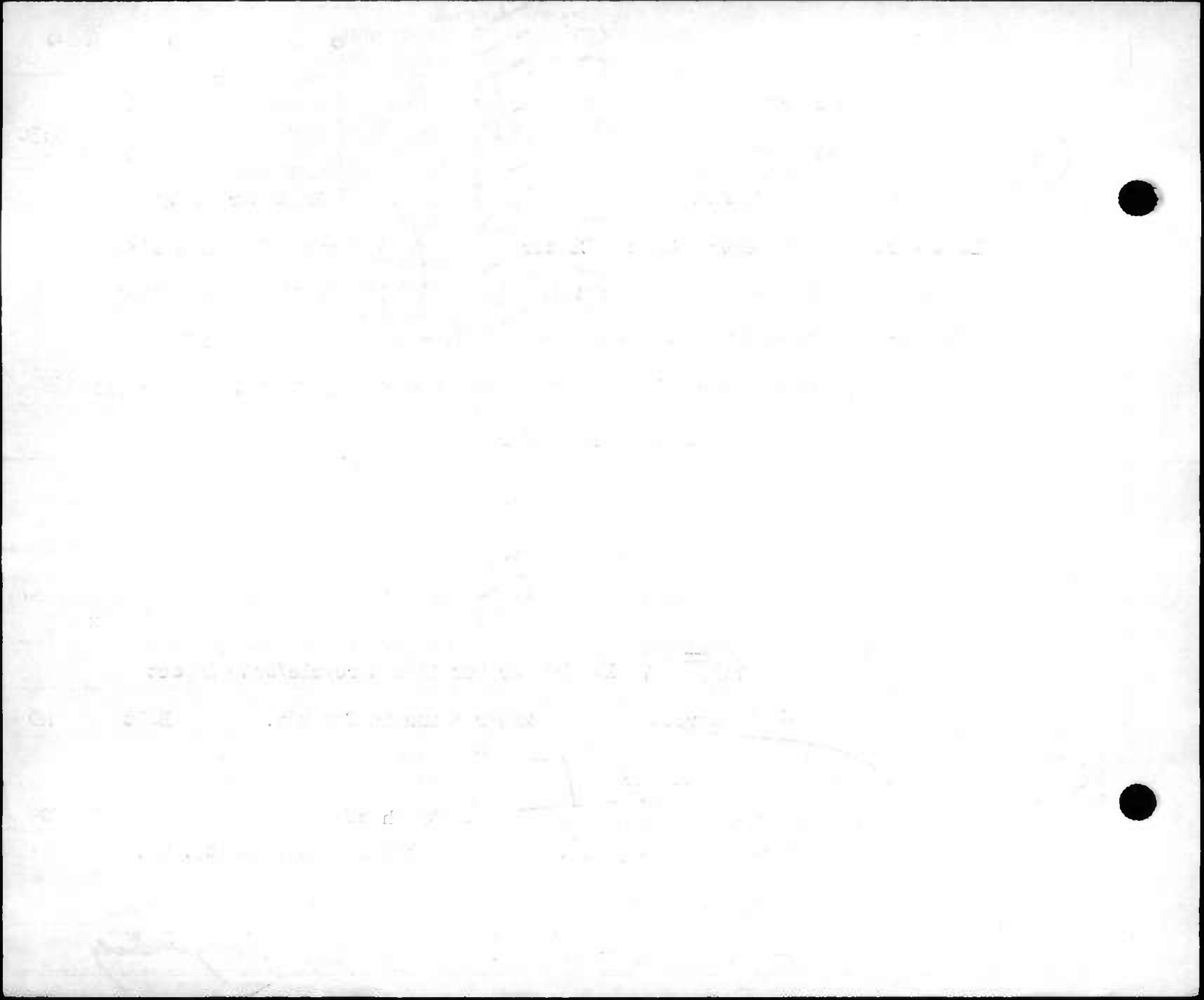
BP

DHMH - 17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |  |                  |  |   |  |   |  |   |  |   |  |   |  |   |  |   |  |  |  |                      |  |
|--|--|------------------|--|---|--|---|--|---|--|---|--|---|--|---|--|---|--|--|--|----------------------|--|
| FOR<br>1- STATE REGISTRAR  |  |                  |  |   |  |   |  |   |  | 8 0 2 8 0 4 6   |  |   |  |   |  |   |  |  |  |                      |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Richard C. Flavin Jr.  |  |                  |  |   |  |   |  |   |  | 2a. DATE KNOWN OF DEATH<br>MONTH 11 DAY 17 YEAR 80  |  |   |  |   |  |   |  |  |  | 2b. HOUR<br>M 9 P 30 |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>June 30 1925  |  | 6. AGE (IN YEARS)<br>55 YRS.                                |  | IF UNDER 1 YR.<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD<br>MONTH 11 DAY 17 YEAR 80                                 |  |   |  |   |  |  |  |                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                          |  |   |  |   |  |  |  |                      |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Deaton Medical Center |  |   |  |   |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Regional Dir. N.N. |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Life Corp. |  |  |  |                      |  |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Lutherville   |  |                  |  |   |  |   |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  | 13e. STREET ADDRESS<br>820 Kellogg Rd. 21093  |  |   |  |  |  |                      |  |
| 14. FATHER'S NAME<br>FIRST Richard MIDDLE Campbell LAST Flavin, Sr.  |  |                  |  |   |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST Audrey MIDDLE Lilly LAST                                      |  |   |  |   |  |   |  |  |  |                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>Yes   |  |                  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WWII & Korean 217-12-0953  |  |   |  | 17. INFORMANT ADDRESS<br>Mrs. Dorothy M. Flavin, same as #13e   |  |   |  |   |  |   |  |   |  |  |  |                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Closed head injury<br>8122<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF  |  |                  |  |   |  |   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |  |  |                      |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |  |                  |  |   |  |   |  |   |  |   |  |   |  |   |  |   |  |  |  |                      |  |
| 19a. DATE OF OPERATION   |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  |   |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |  |  |                      |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                  |  | 21b. TIME OF INJURY<br>HOUR 7:50 P.M. MONTH 7 DAY 19 YEAR 80  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)<br>driver in motorcycle/auto impact   |  |   |  |   |  |   |  |   |  |  |  |                      |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK  |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>street   |  |   |  | 21f. LOCATION<br>STREET Manors & Runningfox Rds. CITY OR TOWN Balto. COUNTY MD  |  |   |  |   |  |   |  |   |  |  |  |                      |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                  |  |   |  |   |  |   |  |   |  |   |  |   |  |   |  |  |  |                      |  |
| ACTUAL SIGNATURE<br>Thomas D. Smith, M.D.  |  |                  |  |   |  |   |  |   |  | TITLE (SPECIFY)<br>Deputy Chief M.D.  |  |   |  | DATE SIGNED<br>11/18/80   |  |   |  |  |  |                      |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Thomas D. Smith, M.D.   |  |                  |  |   |  |   |  |   |  | ADDRESS<br>111 Penn ST. Balto., MD.   |  |   |  |   |  |   |  |  |  |                      |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation   |  |                  |  | 23b. DATE<br>11-20-80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Crematory |  |   |  | 23d. LOCATION<br>CITY OR TOWN Baltimore COUNTY Maryland STATE                                   |  |   |  |   |  |   |  |  |  |                      |  |
| 24. FUNERAL DIRECTOR<br>NAME Ruck Towson Funeral Home, Inc. ADDRESS 1050 York Rd.  |  |                  |  |   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 19 1980  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br>Dorothy M. Flavin                                     |  |   |  |  |  |                      |  |



M

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 0 4 7

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>JOHN J. FLETCHER               |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>11 10 80 |   |  | 2b. HOUR<br>1825 M  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>6 5 23   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>57 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New Jersey                                 |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |
| 10. CITY OR TOWN OF DEATH<br>Maryland   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University Hospital |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Seaman  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  |  |  |   |  |   |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>John J. Fletcher                                 |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE<br>Theresa McCabe  |  | 16. STREET ADDRESS<br>1926 Wilkens Avenue   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                    |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>145-18-5913   |  | 17. INFORMANT<br>Roselle Park, N.J.<br>Rose Fletcher 42 W. Grant Ave. 07204   |  |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiac arrest

DUE TO, OR AS A CONSEQUENCE OF

(b) Cardiac failure

DUE TO, OR AS A CONSEQUENCE OF

(c) Inoperable myocardial infarct

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 19a. DATE OF OPERATION<br>11/8/80  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Coronary artery disease |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN VERIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)      |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/8/80 19 to 11/10/80 19, that (I) (we) lost<br>saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br>Albert M. Lai, M.D.  |  |   |  | DEGREE   |  | 22c. DATE SIGNED<br>11/10/80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Albert M. Lai, M.D.   |  |   |  | 22e. ADDRESS<br>22 S. Greene Street.   |  |   |  |

|  |  |                       |  |  |  |  |  |
|--|--|-----------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial     |  | 23b. DATE<br>11-14-80 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>New Cathedral Cemetery |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Hubbard Funeral Home, Inc. |  |                       |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 14 1980                 |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]                        |  |

DHMH-16 25M  
(VRA 15, 4) 1/79

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



*[Faint, mostly illegible text and markings covering the page, possibly bleed-through from the reverse side.]*

NOV 14 1980

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |  |
|---|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |   |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>BABY BOY FOOKS</b>  |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>OCTOBER 25, 1980</b>                                  |  | 2b. HOUR<br><b>03:52AM</b>   |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10/25/80</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS HOURS MIN.<br><b>10/25/80</b>               |  | 7. IF UNDER 1 YEAR<br>IF UNDER 24 HRS  |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BALTIMORE</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. <b>BALTIMORE CITY OR COUNTY OF DEATH</b><br><b>BALTIMORE CITY</b> MD.                        |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>MD.</b>  |  | 13b. COUNTY<br><b>Wic.</b>   |  | 13c. CITY OR TOWN<br><b>CITY</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>BOX 218 PARSONSBURG, MD.</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>DAVID FOOKS</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ALICE FOOKS</b>   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>NONE</b>  |  | 17. INFORMANT ADDRESS<br><b>BOX 218 PARSONSBURG, MD. 21849</b>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b><br><b>7598</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Intractable cephalopathy</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Prematurity 33 weeks</b>   |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/25</b> , 19 <b>80</b> , to <b>10/25</b> , 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>10/25</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Richard Q. Morten</b>  |  |  |  | DEGREE<br><b>M</b>  |  |   |  | 22c. DATE SIGNED<br><b>10/25/80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RICHARD A. MORTEN</b>   |  |  |  | 22e. ADDRESS<br><b>JOHNS HOPKINS HOSPITAL BALTIMORE MD.</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>CREMATION</b>   |  | 23b. DATE<br><b>10/25/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>JOHNS HOPKINS HOSPITAL</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO, MD.</b>                                 |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>JOHNS HOPKINS HOSPITAL</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 13 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Richard Q. Morten</b>  |  |  |  |

BP

05 35 01

05 35 01

05

05

05 35 01



## MEDICAL CERTIFICATION

DHMH-16 30M 2/80  
(VRA 15, 4)



NO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |  |  | REG. NO. 80 28050                                |  |
|--|--|---|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Dennis D. Foreman</b>  |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 4, 1980</b>   |  | 2b. HOUR<br><b>5:30a</b> M                       |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 8 1919</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>61</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                         |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Factory Worker</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  |   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>2405 Ething Street</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>LAWRENCE FOREMAN</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>DAISEY</b>  |  |   |  | 17. INFORMANT ADDRESS<br><b>ROSA FOREMAN 2405 Ething Street</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>217-05-1042-A</b>   |  |   |  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>1509 Pulmonary embolus to right middle lobe and right lower lobe and left lower lobe</b><br>IMMEDIATE CAUSE (a) } DUE TO, OR AS A CONSEQUENCE OF<br>(b) } <b>Esophageal carcinoma</b><br>(c) } DUE TO, OR AS A CONSEQUENCE OF<br><b>Lipoid pneumonia with....</b> |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Pulmonary Tuberculosis, right upper lobe and right middle lobe</b>  |  |   |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>11/3/80</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Esophageal Carcinoma</b>   |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>      |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |  |  |
| 22a. I certify that (X) (this hospital) attended the deceased from <b>October 12, 19 80</b> , to <b>November 4, 19 80</b> , that (X) (we) last saw the deceased alive on <b>November 4, 19 80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) did (did not) view the body after death.                       |  |   |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>W. A. Patterson M.D.</b>  |  |   |  | DEGREE<br><b>AD</b>   |  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11/4/80</b>               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>W. Wiley A. Patterson, M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>11/8/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt Auburn Cem.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>                  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Wm. Brown Community Funeral Home</b>  |  |   |  | ADDRESS<br><b>206-08 W. North Ave.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 10 1980</b>                                       |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |  |  |

MEDICAL CERTIFICATION

1303 BP 5

1924

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

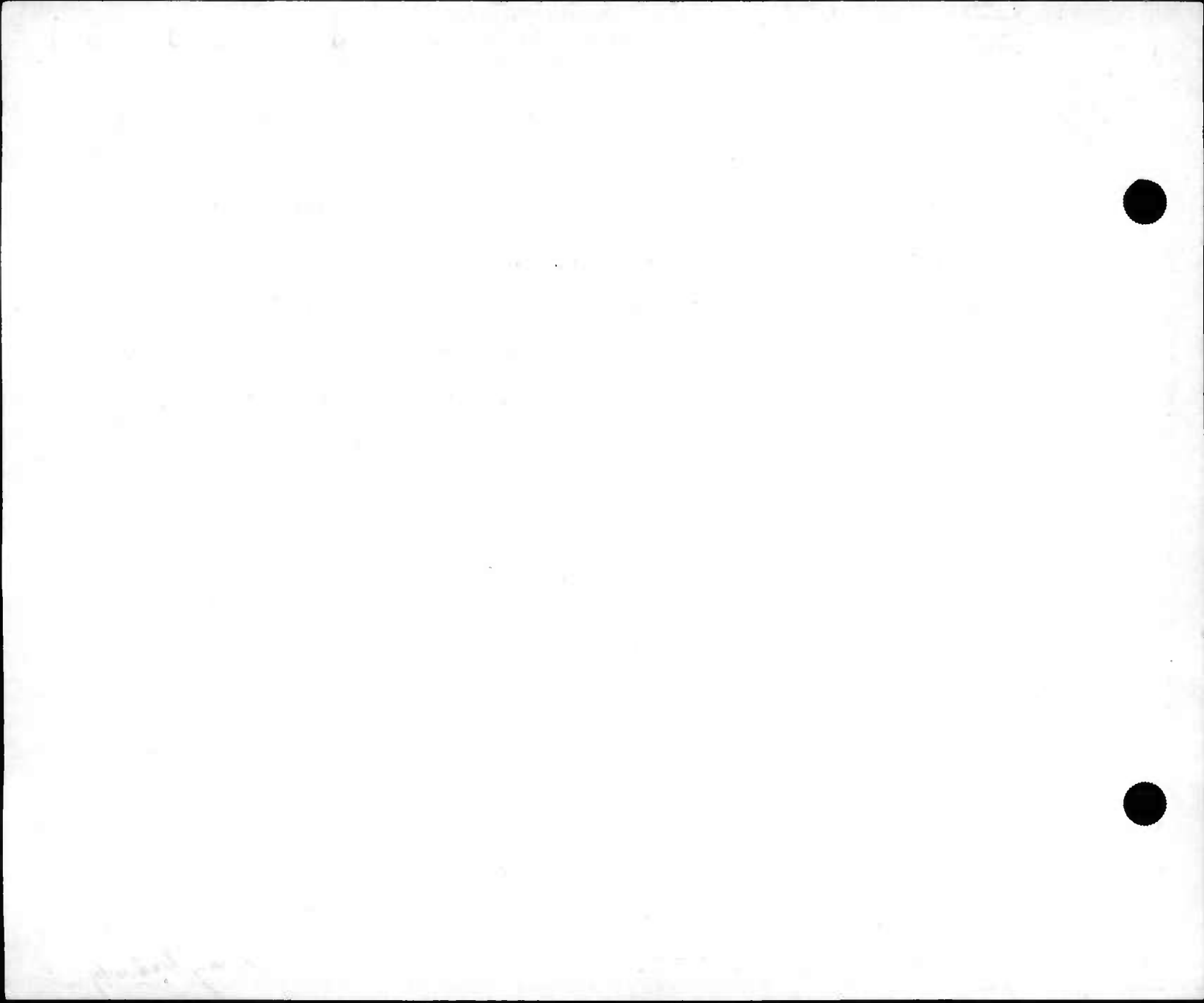
80 28051

REG. NO.

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>IOLA M. FORREST  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 20 80                    |  | 2b. HOUR<br>M  |
| 3. SEX<br>Female   | 4. RACE<br>Negro   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 8 1900  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>80 YRS                          |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.        |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Good Samaritan Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  |   | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Baltimore   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Henry Madison  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Henrietta Madison |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>218-09-0870   |  | 17. INFORMANT<br>ADDRESS<br>Amanda Gilliard 5912 Fenwick Avenue                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hypertensive Heart Disease</u><br>4029<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/23/80</u> 19 <u>80</u> , to <u>10/17/80</u> , that (I) (we) last saw the deceased alive on <u>10/14</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.                     |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Edom N. Coker</u>   |  | DEGREE<br>MD.   |  | 22c. DATE SIGNED<br>11/25/80   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ODOM N. COKEA MD.   |  | 22e. ADDRESS<br>3701 Liberty Hg. Ave., Baltimore Md.  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   | 23b. DATE<br>11/25/80  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Co., Maryland          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F.H., Inc./1101 E. North Ave.   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 28 1980  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Ricky Hebert</u>                              |  |

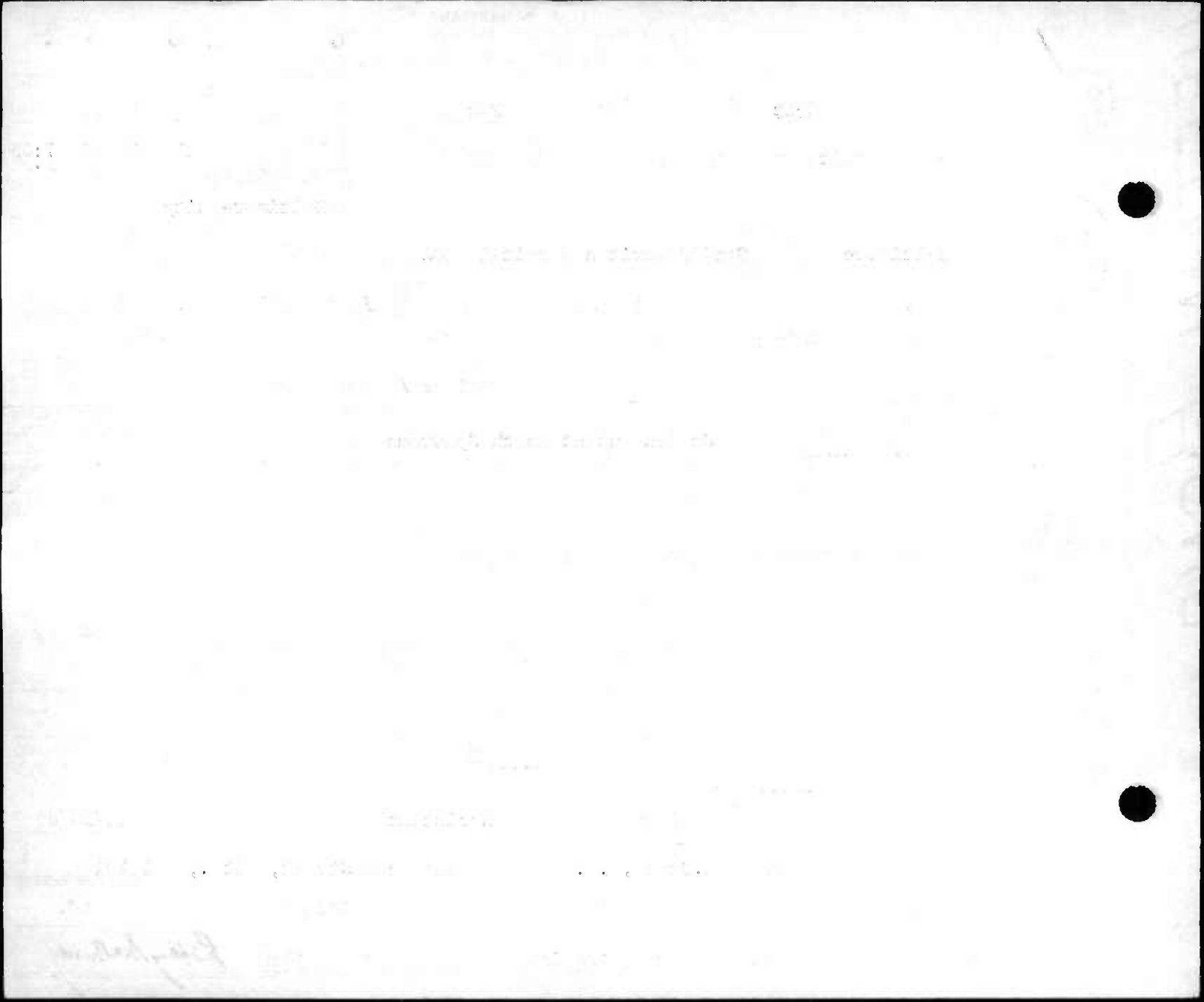
BP

DHMH-16 20M  
(VRA 15, 4) 7/78



2 8 0 5 2

DHMH - 17  
(VR A15 ME (5))  
15M2/BO





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |   |  |  |                                       |  |   | 80 28053 |  |
|--|--|---|--|---|--|--|---------------------------------------|--|---|----------|--|
| 1 - FOR STATE REGISTRAR  |  |   |  |   |  |  |                                       |  |   | REG. NO. |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>IRENE — FRAILER</b>   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 5 80</b>                        |  |                                       | 2b. HOUR<br><b>202A</b>  |   |          |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>white</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>04 12 98</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b> YRS.                                    |                                       | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |   |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>USA MD</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                    |                                       |  |   |          |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>South Baltimore Gen Hosp.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |                                       | 12b. KIND OF BUSINESS OR INDUSTRY  |   |          |  |
| 13a. STATE<br><b>MD</b>  |  |   |  |   | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b> |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Julius — ACKERMAN</b>   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Catherine T — RAMING</b> |  |                                       |  |   |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>215-09-4811</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Madalene Williams, 177 Carroll Rd. Riviera Beach</b>  |  |  |                                       |  |   |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiovascular failure</b><br><b>5140</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>pulmonary edema / Hypoxia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |  |  |                                       |  |   |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____  |  |   |  |   |  |  |                                       |  |   |          |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |                                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |                                       |  |   |          |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |                                       |  |   |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/30</b> , 19 <b>80</b> , to <b>11/5</b> , 19 <b>80</b> , that (I) (we) lost<br>saw the deceased alive on <b>11/5</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |                                       |  |   |          |  |
| 22b. SIGNATURE<br><b>Sandra L. Howard</b> M.D.<br>DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>   |  |   |  |   |  | 22c. DATE SIGNED   |                                       |  |   |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Sandra L. Howard</b>   |  |   |  | 22e. ADDRESS<br><b>3001 S. HANOVER ST.</b>  |  |  |                                       |  |   |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Nov. 8, 1980</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem. Park</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glen Burnie, A.A. Co. Maryland</b>  |                                       |  |   |          |  |
| 24. FUNERAL DIRECTOR<br><b>McClully Funeral Home, 130 E. Ford Ave. Balto. Md.</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 5 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>L. J. M. M. M.</b>                                  |                                       |  |   |          |  |

BP



UNITED STATES  
DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

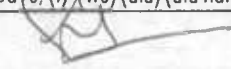

*[Faint, mostly illegible text and markings covering the majority of the page, possibly representing a botanical specimen record or a form.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

2 8 0 5 4

|   |  |  |  |   |                          |
|---|--|--|--|---|--------------------------|
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br><b>Erva M. Francis</b>   |  |  | 2a. DATE OF DEATH<br>Month Day Year<br><b>11 15 80</b> |   | 2b. HOUR<br><b>8 A M</b> |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Negro</b>  |  | 5. DATE OF BIRTH<br><b>1/10/86</b>  |                          |
| 6. AGE (In years lost birthday)<br><b>94 YRS.</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.  |                          |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                          |
| 9. COUNTY OF DEATH<br><b>Baltimore City</b> Md.   |  |  |  |   |                          |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Maryland Baptist Aged Home</b>                      |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Housewife</b>   |                          |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. STREET AND NUMBER<br><b>738 Dolphin Street</b>   |                          |
| 14. FATHER'S NAME First Middle Last<br><b>Harry Pernell</b>   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Emma Jackson</b>  |  |   |                          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or <u>unknown</u> )   |  | 16b. SOCIAL SECURITY NO.<br><b>214-74-7210</b>   |  | 17. INFORMANT Address<br><b>Janet Dawson/RN Maryland Baptist Aged Home</b>  |                          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Pulmonary Embolism</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Fracture of H1P</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |                          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |   |                          |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                          |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |  |  |   |                          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/><br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                          |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |                          |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11-12-1980</u> , to <u>11-15-1980</u> , that (I) (we) last saw the deceased alive on <u>11-15-1980</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |                          |
| 22b. SIGNATURE<br>   |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11-18-80</b>   |                          |
| 22d. PHYSICIAN'S NAME (Type)<br><b>K. NAIR</b>  |  | 22e. ADDRESS   |  |   |                          |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>11/19/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn</b>   |                          |
| 23d. LOCATION (City or Town) (County) (State)<br><b>Balto. Md.</b>  |  |  |  |   |                          |
| 24. FUNERAL DIRECTOR<br><b>Locks FUNERAL Home</b>   |  | ADDRESS<br><b>1304 N. Central St</b>   |  | 25a. REC'D BY REGISTRAR<br><b>NOV 19 1980</b>   |                          |
| 25b. REGISTRAR'S SIGNATURE<br>   |  |  |  |   |                          |

1

28055

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Joseph Henry Frank</b>   |  | 2a. DATE OF DEATH<br>MONTH DAY HOUR<br><b>November 14, 1980</b>  |  | 2b. HOUR<br>MIN.  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>April 26, 1907</b>   |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>0 0</b>  |  | 8. IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 9b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD                                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2839 Chesterfield Avenue</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Acc't. State of Maryland</b> |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph H. Frank</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary A. Athman</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                   |  |
| 16b. SOCIAL SECURITY NO.<br><b>213-05-2418</b>   |  | 17. INFORMANT<br><b>Wife: Mary P. Frank</b>  |  | 18. ADDRESS<br><b>Balt., Md. 21213<br/>2839 Chesterfield Avenue</b>                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Coronary occlusion</u><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>H. C.V. H. disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Months</u><br><u>year</u> |  |  |  |   |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                           |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                      |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5-10-74</u> , 19 <u>80</u> , to <u>11-7-80</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>11-7</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |
| 22b. SIGNATURE<br><u>William L. Fearing M.D.</u> DEGREE  |  |  |  | 22c. DATE SIGNED<br><u>11-15-80</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. William L. Fearing M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>3025 Belair Road Baltimore, Maryland</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Nov 17 1980</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Most Holy Redeemer</b>                                     |  |
| 23d. LOCATION<br>CITY OR TOWN<br><b>Baltimore</b>  |  | 23e. COUNTY<br><b>Maryland</b>   |  | 23f. STATE<br><b>Maryland</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Leonard J. Ruck, Inc. Baltimore, Maryland</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 17 1980</b>   |  |



November 14, 1943

Frank

Henry

Joseph

73

April 20, 1947

Marie

Ala

Beltsville City

x

U.S.A.

Beltsville

And... of Beltsville

2659 Chestnut St Avenue

Beltsville

Beltsville, Md. 21735

2659 Chestnut St Avenue

x

Beltsville

Beltsville

Alman

Alman

Henry

Henry

Alman

Joseph

Alman, A. A. 21735

2659 Chestnut St Avenue

May 2, 1947

2659 - 2659

Ala

*Handwritten:* H.C. 11/1/47

Nov 15

2659 Beltsville, Md.

Dr. William L. ...

Beltsville

Beltsville

Beltsville

Nov 17 1943

Beltsville

Beltsville, Md. 21735

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 2 8 0 5 6  
CERTIFICATE OF DEATH

|   |  |  |  |
|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO.   |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | 2a. DATE OF DEATH  |  |
| THOMAS L. FRANKLIN  |  | 11/25/80   |  |
| 3. SEX  |  | 4. RACE  |  |
| Male  |  | Negro  |  |
| 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  |
| 4 MONTH 2 YEAR 24   |  | 56   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |
| MD  |  | USA  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                                     |  |
| Baltimore   |  | JOHNS HOPKINS HOSPITAL   |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
|   |  |  |  |
| 13a. STATE  |  | 13b. COUNTY  |  |
| MD  |  |  |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  |
| Leroy   |  | Beatrice F.  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  |
| Yes   |  | 212-20-7990  |  |
| 17. INFORMANT   |  | ADDRESS  |  |
| Florence T. Franklin  |  | 2035 Sinclair Lane   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 1. DEATH WAS CAUSED BY:  |  |  |  |
| IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST  |  | 5 MIN  |  |
| 4375  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |
| (b) HYPOTENSION   |  | 3 HRS  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |
| (c) CENTRAL NERVOUS SYSTEM DYSFUNCTION  |  | 24 HRS   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |
| ANOXIC BRAIN DAMAGE; POST CARDIOPULMONARY ARREST  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
|   |  |  |  |
| 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?   |  |
| YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY  |  |
|   |  | HOUR A.M. MONTH DAY YEAR   |  |
|   |  | P.M. 19  |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |
| WHILE <input type="checkbox"/> AT WORK OR NOT WHILE <input type="checkbox"/> AT WORK  |  |  |  |
| 21f. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  | 21g. LOCATION  |  |
|   |  | STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from NOV 23, 19 80, to NOV 25, 19 80, that (I) (we) lost saw the deceased alive on NOV 25, 19 80, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (not) view the body after death. |  |  |  |
| 22b. SIGNATURE  |  | DEGREE   |  |
| Steven T. Kariya  |  | MD   |  |
| 22c. DATE SIGNED  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |
| 11-25-80  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |
| STEVEN T. KARIYA  |  | JOHNS HOPKINS HOSP, BALTIMORE MD 21205   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  |
| Burial  |  | 12/1/80  |  |
| 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION  |  |
| Crownsville VA Cem.   |  | Crownsville  |  |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REC'D. BY REGISTRAR  |  |
| Wm. C. March F/H 1101 E. North Ave.   |  | NOV 28 1980  |  |
| 25b. REGISTRAR'S SIGNATURE  |  |  |  |
|   |  |  |  |



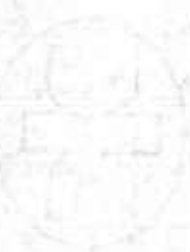
582:6

RECEIVED

RECEIVED



RECEIVED



RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 0 2 8 0 5 7   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Dawn NMN Frasier</b>   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 3, 1980</b>  |  | 2b. HOUR<br><b>5:30P M</b>   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Apr. 22 1931</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>49</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Chicago, Ill.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Clerk</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Crd. Union</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  | 13b. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 13a. STATE<br><b>Md.</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13. STREET ADDRESS<br><b>1319 N. Calvert St.-21202</b>  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Roy Andrew Frasier</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Otylia Libose Trefil</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>332-26-7124</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Brother Thomas D. Frasier - 1319 N. Calvert St. 21202</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of the Breast with Pulmonary Metastasis</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>October 27, 1980</b> to <b>November 3, 1980</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>November 3, 1980</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. ( <input checked="" type="checkbox"/> we) ( <input type="checkbox"/> did) ( <input type="checkbox"/> did not) view the body after death. |  |   |  |   |  |  |  |
| 27a. SIGNATURE<br><i>Craig R. Martin</i>  |  |   |  | DEGREE<br><i>MD</i>   |  | 27b. DATE SIGNED<br><i>11/3/80</i>   |  |
| 27c. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Craig R. Martin, M.D.</b>   |  |   |  | 27d. ADDRESS<br><b>Maryland General Hospital</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>Nov. 4, 1980</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Security Process</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Catonsville, Balto., Md.</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Stewart &amp; Mowen Co. 108 W. North Av., City 21201</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 10 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |

MEDICAL CERTIFICATION

9 9

1101 BP 4

November 2, 1930

Franklin

NEW

San

49

1931

1931

Chicago

Chicago

Chicago, Ill.

Chicago, Ill.

Chicago, Ill.

Chicago, Ill.

Chicago, Ill.

Chicago, Ill.

Chicago, Ill.

Chicago, Ill.

Chicago, Ill.

Chicago, Ill.

Chicago, Ill.

Chicago, Ill.

Chicago, Ill.

Chicago, Ill.

Chicago, Ill.

Chicago, Ill.

Chicago, Ill.

Chicago, Ill.

Chicago, Ill.

Chicago, Ill.

Chicago, Ill.

Chicago, Ill.

Chicago, Ill.

Chicago, Ill.

Chicago, Ill.

Chicago, Ill.

Chicago, Ill.

Chicago, Ill.

Chicago, Ill.

Chicago, Ill.

Chicago, Ill.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80

28058

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |   |                       |  |
|---|--|---|---|---|-----------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>LORA FRAZIER  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>NOVEMBER 28, 1980      |   | 2b. HOUR<br>6:30 P.M. |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Negro  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 9 16                                      |                       |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>64 YRS   |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>N.C.   |   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |                       |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.  |   |   |                       |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                  |                       |  |
| 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |   |   |                       |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE MD 13b. COUNTY 13c. CITY OR TOWN Baltimore 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 2201 Orleans St.   |  |   |   |   |                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Dudley   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Belle Dudley |   |                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>237-03-7462   |   | 17. INFORMANT ADDRESS<br>Cynthia Frazier 2201 Orleans St.                         |                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory arrest</u><br>0389<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Sepsis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |   |   |   |                       |  |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |   |   |                       |  |
| MEDICAL CERTIFICATION   |  |   |   |   |                       |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                       |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |   |   |                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |                       |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                 |                       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/30</u> 19 <u>80</u> , to <u>11/28</u> 19 <u>80</u> , that (I) (we) lost<br>saw the deceased alive on <u>1/28</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |                       |  |
| 22b. SIGNATURE<br>Robert Redner MD  |  | DEGREE  |   | 22c. DATE SIGNED<br>11/28/80  |                       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Robert Redner  |  | 22e. ADDRESS<br>Johns Hopkins Hosp. Bldg.   |   |   |                       |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>12/4/80  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Mem. Pk.                           |                       |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Co. MD  |  |   |   |   |                       |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H 1101 E. North Ave.   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>DEC 4 1980                                       |                       |  |
|   |  |   |   | 25b. REGISTRAR'S SIGNATURE<br>Anthony M. Brady                                    |                       |  |

10



**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

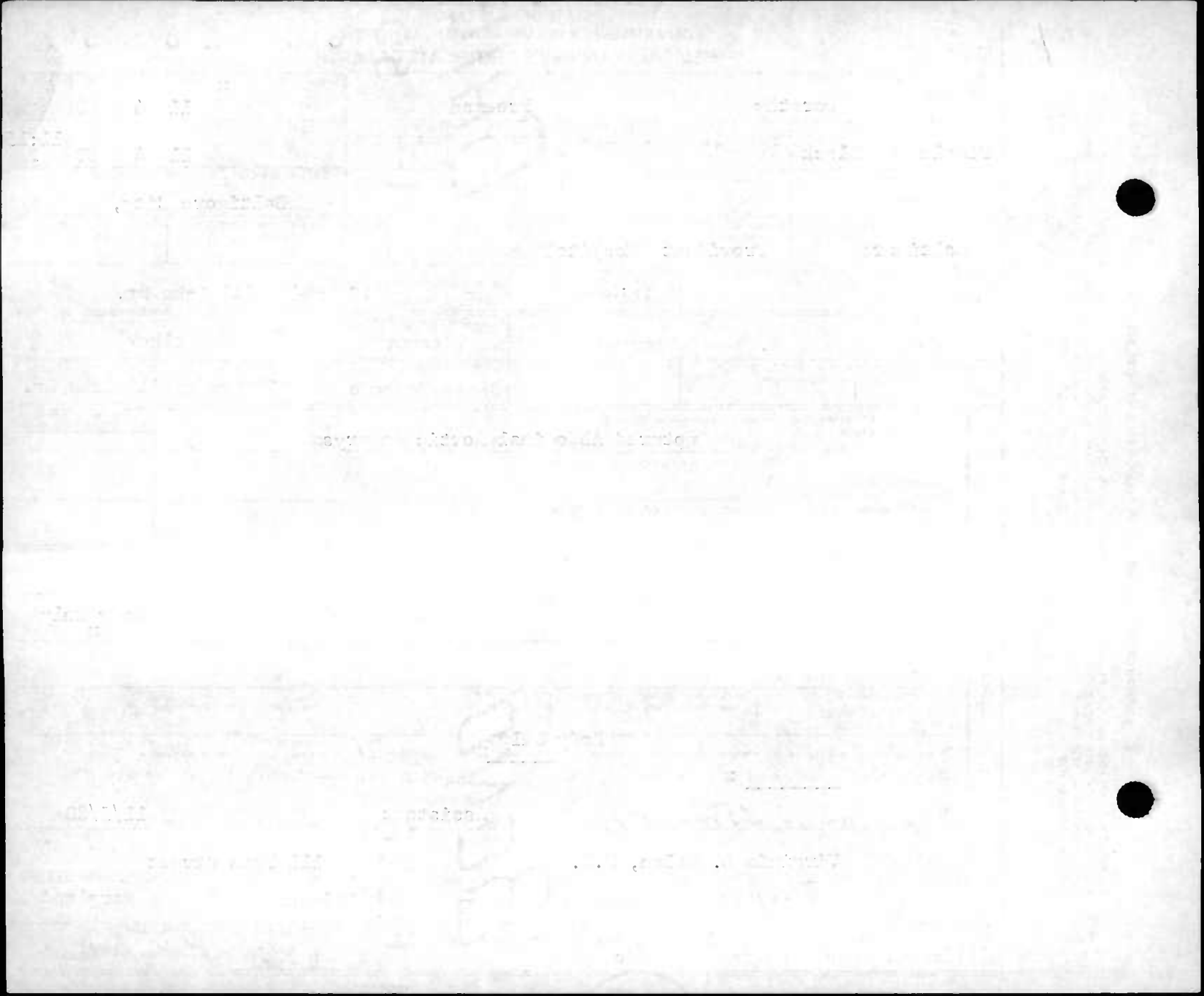
REG. NO.

|   |         |   |  |   |  |   |  |                                      |  |  |  |       |  |      |  |          |  |
|---|---------|---|--|---|--|---|--|--------------------------------------|--|--|--|-------|--|------|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |         | FIRST   |  | MIDDLE  |  | LAST  |  | 2a. DATE KNOWN OF DEATH              |  | MONTH  |  | DAY   |  | YEAR |  | 2b. HOUR |  |
| Dorothy   |         |   |  | Freeman   |  |   |  | 11                                   |  | 4  |  | 19    |  | 80   |  | 11:15 PM |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS.                     |  | 7c. DATE PRONOUNCED DEAD                     |  | MONTH |  | DAY  |  | YEAR     |  |
| Female  | Black   | 11 13 05  |  | 74  |  |   |  |                                      |  | 11   |  | 4     |  | 19   |  | 80       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?                                |  | 8. MARRIED  |  | NEVER MARRIED   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |  |  |       |  |      |  |          |  |
| New Jersey  |         | USA   |  | WIDOWED   |  | DIVORCED  |  | Baltimore City,                      |  |  |  |       |  |      |  | MD.      |  |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION    |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                                      |  |  |  |       |  |      |  |          |  |
| Baltimore   |         | Provident Hospital  |  |   |  |   |  |                                      |  |  |  |       |  |      |  |          |  |
| 13a. STATE  |         | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS                  |  |  |  |       |  |      |  |          |  |
| Maryland  |         |   |  | Baltimore   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 717 Druid Hill Lake Dr.              |  |  |  |       |  |      |  |          |  |
| 14. FATHER'S NAME   |         | 15. MOTHER'S MAIDEN NAME                                    |  |   |  |   |  |                                      |  |  |  |       |  |      |  |          |  |
| John  |         | Eleanor   |  |   |  |   |  |                                      |  |  |  |       |  |      |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  |         | 16b. SOCIAL SECURITY NO.                                    |  | 17. INFORMANT   |  | ADDRESS   |  |                                      |  |  |  |       |  |      |  |          |  |
| (YES, NO, OR UNKNOWN)   |         |   |  | James Newsome   |  | 717 Druid Hill Lake Dr.   |  |                                      |  |  |  |       |  |      |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                |  |   |  |   |  |                                      |  |  |  |       |  |      |  |          |  |
| PART I DEATH WAS CAUSED BY:   |         |   |  |   |  |   |  |                                      |  |  |  |       |  |      |  |          |  |
| IMMEDIATE CAUSE (a) <b>Ruptured Abdominal Aortic Aneurysm</b>   |         |   |  |   |  |   |  |                                      |  |  |  |       |  |      |  |          |  |
| 4413  |         |   |  |   |  |   |  |                                      |  |  |  |       |  |      |  |          |  |
| DUE TO, OR AS A CONSEQUENCE OF  |         |   |  |   |  |   |  |                                      |  |  |  |       |  |      |  |          |  |
| (b)   |         |   |  |   |  |   |  |                                      |  |  |  |       |  |      |  |          |  |
| DUE TO, OR AS A CONSEQUENCE OF  |         |   |  |   |  |   |  |                                      |  |  |  |       |  |      |  |          |  |
| (c)   |         |   |  |   |  |   |  |                                      |  |  |  |       |  |      |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |         |   |  |   |  |   |  |                                      |  |  |  |       |  |      |  |          |  |
| 19a. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  | 20. AUTOPSY?  |  |   |  |                                      |  |  |  |       |  |      |  |          |  |
|   |         |   |  | Body Only   |  |   |  |                                      |  |  |  |       |  |      |  |          |  |
| 21a. EXTERNAL CAUSE WAS   |         | 21b. TIME OF INJURY   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |  |                                      |  |  |  |       |  |      |  |          |  |
| UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         | HOUR A.M. MONTH DAY YEAR                                    |  |   |  |   |  |                                      |  |  |  |       |  |      |  |          |  |
|   |         | P.M. 19   |  |   |  |   |  |                                      |  |  |  |       |  |      |  |          |  |
| 21d. INJURY OCCURRED  |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  | 21f. LOCATION   |  |   |  |                                      |  |  |  |       |  |      |  |          |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>   |         |   |  | CITY OR TOWN  |  | COUNTY  |  | STATE                                |  |  |  |       |  |      |  |          |  |
| AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |         |   |  |   |  |   |  |                                      |  |  |  |       |  |      |  |          |  |
| 22a. I certify that I took charge of the remains described above, held an   |         | Autopsy <input checked="" type="checkbox"/>                 |  | Inspection <input type="checkbox"/>   |  | Inquiry <input type="checkbox"/>                                    |  | and in my opinion                    |  |  |  |       |  |      |  |          |  |
| death resulted from:  |         | Natural causes <input checked="" type="checkbox"/>          |  | Accident <input type="checkbox"/>   |  | Suicide <input type="checkbox"/>                                    |  | Homicide <input type="checkbox"/>    |  | Undetermined manner <input type="checkbox"/> |  |       |  |      |  |          |  |
| ACTUAL SIGNATURE  |         | TITLE (SPECIFY)   |  | DATE SIGNED   |  |   |  |                                      |  |  |  |       |  |      |  |          |  |
| Virginia L. Dolan   |         | Assistant   |  | 11/5/80   |  |   |  |                                      |  |  |  |       |  |      |  |          |  |
| EXAMINER'S NAME   |         | ADDRESS   |  |   |  |   |  |                                      |  |  |  |       |  |      |  |          |  |
| (TYPE OR PRINT)   |         | 111 Penn Street   |  |   |  |   |  |                                      |  |  |  |       |  |      |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL   |         | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION   |  |                                      |  |  |  |       |  |      |  |          |  |
| Cremation   |         | 11/11/80  |  | Westview Cemetery   |  | Baltimore   |  |                                      |  |  |  |       |  |      |  |          |  |
| 24. FUNERAL DIRECTOR  |         | 25a. DATE REC'D. BY REGISTRAR                               |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |                                      |  |  |  |       |  |      |  |          |  |
| NAME  |         | 1101 E. North Avenue  |  | NOV 10 1980   |  |   |  |                                      |  |  |  |       |  |      |  |          |  |
| William C. March Funeral Home Inc   |         |   |  |   |  |   |  |                                      |  |  |  |       |  |      |  |          |  |

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

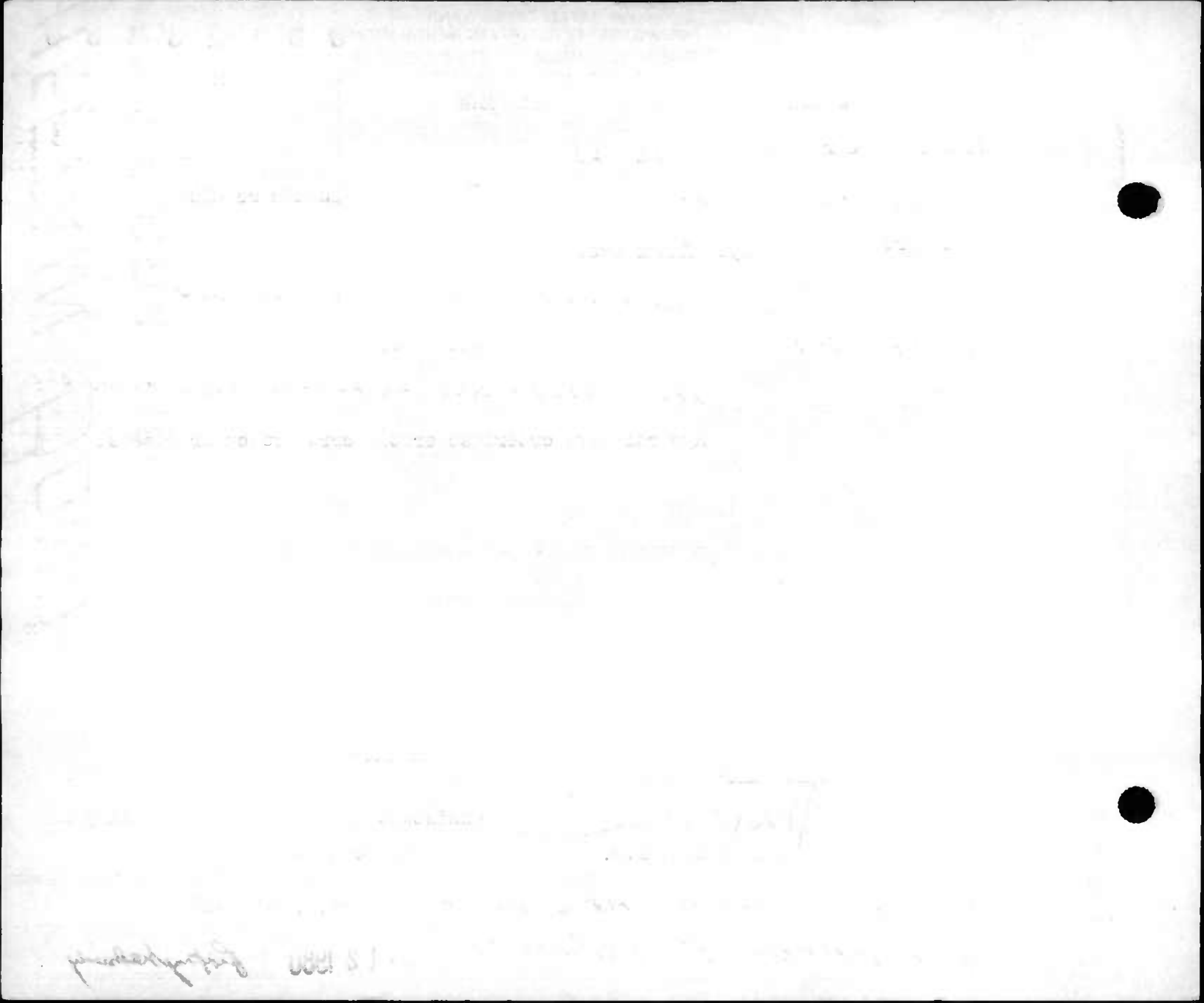
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGES 1, 2, AND 3 OF YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE RETURNED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                  |  |  |  |  |  |  |  | REG. NO. 28060   |  |
|--|--|------------------|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |                  |  |  |  |  |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>JENNIE B. FREEMAN  |  |                  |  |  |  |  |  |  |  | 2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR<br>11 8 1980                    |  |
| 3. SEX<br>female   |  | 4. RACE<br>negro |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>10 28 12  |  | 6. AGE (IN YEARS) (LAST BIRTHDAY) MONTHS DAYS HOURS MIN<br>68 YRS                            |  | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR<br>11 8 1980   |  | 2b. HOUR<br>5:06 P M   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pittsburgh Pa   |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                        |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1920 Riggs Ave. |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                  |  |  |  |  |  |  |  |  |  |
| 13a. STATE<br>MD   |  | 13b. COUNTY      |  | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>1920 Riggs Ave  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Henry C. H. Y   |  |                  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Martha   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br>NO   |  |                  |  | 16b. SOCIAL SECURITY NO.<br>186-05-7237-A  |  | 17. INFORMANT ADDRESS<br>William Freeman 1920 Riggs Ave                                      |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>4029 IMMEDIATE CAUSE (a) Hypertensive arteriosclerotic cardiovascular disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                     |  |                  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                     |  |
| 19a. DATE OF OPERATION   |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <del>Natural cause</del> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                  |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE<br>Ann M. Dixon, M.D.   |  |                  |  | TITLE (SPECIFY)<br>Assistant MEDICAL EXAMINER  |  |  |  | DATE SIGNED<br>11-9-80   |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Ann M. Dixon, M.D.  |  |                  |  | ADDRESS<br>111 Penn St.  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (LOCATION)<br>Burial   |  |                  |  | 23b. DATE<br>11/13/80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt Auburn  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore MD  |  |  |  |
| 24. FUNERAL DIRECTOR<br>Maryland Home Health Care  |  |                  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 12 1980   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br>F. J. Kelly  |  |  |  |





FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 2 8 0 6 1  
CERTIFICATE OF DEATH

REG. NO.

|   |   |  |   |  |   |
|---|---|--|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Thomas J. FREEMAN</b>  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11-23-80</b>  |  | 2b. HOUR<br><b>445 P.M.</b>   |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>WHITE</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2-16-18</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b>   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N.C.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                    |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University of MD Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR WHICH PAID)<br><b>EXEC. V. PRES.</b>                 |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>PIPING</b>  |
| 13a. STATE<br><b>NC</b>   | 13b. COUNTY<br><b>UNION</b>   | 13c. CITY OR TOWN<br><b>MONROE</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>RT 6 BX 215</b>  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Thomas HENDRICKS</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>LOW KELLY</b>  |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> IF YES, GIVE SERVICE)<br><b>YES WWII</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>251-01-4944</b>   |   | 17. INFORMANT (WIFE) ADDRESS<br><b>LAVERNE FREEMAN SAME AS #13</b>                   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MALIGNANT mesothelioma</b><br><b>1991</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>8/80 - 11/23/80</b><br><b>3 mo.</b> |   |  |   |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |   |  |   |  |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on <b>23 NOV 1980</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |   |  |   |  |   |
| 22b. SIGNATURE<br><b>Sidney M. Crain MD</b>   |   |  |   | DEGREE   | 22c. DATE SIGNED<br><b>11-23-80</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SIDNEY M. CRAIN MD</b>  |   |  |   | 22e. ADDRESS<br><b>235 GREENE ST. Baltimore MD</b>                                   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |   | 23b. DATE<br><b>11/27/80</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>FORESTLAWN EAST</b>                         |   |
| 23d. LOCATION<br>CITY OR TOWN<br><b>UNION</b>   |   | COUNTY<br><b>A.C.</b>  |   | STATE  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>E. BARNES</b>  |   | ADDRESS<br><b>21018 BENSON, MD</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 1 1980</b>                                   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Ricky Rabun</b>  |   |  |   |  |   |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

OFFICE OF THE SECRETARY



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

10 87 80

2 8 8 6 2

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |  |  |   |  |  |  |  |  |   |  |  |
|---|--|--|--|--|--|---|--|--|--|--|--|---|--|--|
| DECEASED NAME<br>(TYPE OR PRINT)<br><b>TONIQUE</b>  |  |  | MIDDLE<br><b>FREEMAN</b>   |  |  | LAST<br><b>FREEMAN</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10/23/80</b>   |  |  | 2b. HOUR<br><b>12:13a</b>                                       |  |  |
| 3. SEX<br><b>female</b>   |  |  | 4. RACE<br><b>BLACK</b>  |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10/07/ 80</b>  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>10 16</b>  |  |  | IF UNDER 1 YEAR<br>IF UNDER 24 HRS                              |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BALTIMORE</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. <b>BALTIMORE CITY OR COUNTY OF DEATH</b><br><b>BALTIMORE CITY</b>   |  |  | MD.   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br><b>BALTIMORE</b>   |  |  | 13b. CITY<br><b>CITY</b>   |  |  | 13c. CITY OR TOWN<br><b>CITY</b>  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                       |  |  | 13e. STREET ADDRESS<br><b>110 SOUTH STREET</b>                  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>GEORGE</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>STEPHANIE</b>  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(IF YES, GIVE WAR OR DATES)<br><b>NO</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>NONE</b>  |  |  | 17. INFORMANT<br>ADDRESS<br><b>110 SOUTH ST.</b>                |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Necrotizing enterocolitis &amp; bowel perforation</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Irreversible shock</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hours</b> |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Prematurity</u>   |  |  |  |  |  |   |  |  |  |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/23</u> , 19 <u>80</u> , to <u>10/23</u> , 19 <u>80</u> , that (I) (we) lost<br>saw the deceased alive on <u>10/23</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |   |  |  |  |  |  |   |  |  |
| 22b. SIGNATURE<br><u>Richard A. Molteni</u>   |  |  |  |  |  | DEGREE<br><u>MD</u>   |  |  |  |  |  | 22c. DATE SIGNED  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>RICHARD A. MOLTENI</u>  |  |  |  |  |  | 22e. ADDRESS<br><u>JOHNS HOPKINS HOSP. BALTIMORE MD.</u>  |  |  |  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>CREMATION</b>  |  |  | 23b. DATE<br><b>10/23/80</b>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>JOHNS HOPKINS HOSPITAL</b>   |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO, MD.</b>  |  |  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>JOHNS HOPKINS HOSPITAL</b>   |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 13 1980</b>   |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Richard A. Molteni</u>  |  |  |   |  |  |

10055-96

30101 APR 27 1957

22819 206100-1122

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 28063

REG. NO.

|  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |                                |  |  |                                |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--------------------------------|--|--|--------------------------------|--|--|
| 1. FOR STATE REGISTRAR   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |  | 2b. HOUR   |  |  |  |  |  |   |  |  |                                |  |  |                                |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  | 3. SEX   |  |  | 4. RACE  |  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  |  | 7. IF UNDER 1 YEAR MONTHS DAYS |  |  | 8. IF UNDER 24 HRS. HOURS MIN. |  |  |
| JACK (JACOB) FRIEDMAN  |  |  | MALE   |  |  | WHITE  |  |  | 11 21 12   |  |  | 67  |  |  |                                |  |  |                                |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |   |  |  |                                |  |  |                                |  |  |
| NEW YORK   |  |  | USA  |  |  |  |  |  | CITY   |  |  |   |  |  |                                |  |  |                                |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |   |  |  |                                |  |  |                                |  |  |
| BALTO.   |  |  | SHAR HOSPITAL  |  |  | SALESMAN   |  |  | GEN. MDSE.   |  |  |   |  |  |                                |  |  |                                |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  | 13b. COUNTY  |  |  | 13c. CITY OR TOWN  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET ADDRESS   |  |  |                                |  |  |                                |  |  |
| MD   |  |  | BALTO  |  |  | BALTO  |  |  |  |  |  | 3012 FALLSTAFF RD. D 21209  |  |  |                                |  |  |                                |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |  |  |  |  |  |  |   |  |  |                                |  |  |                                |  |  |
| ISRAEL FRIEDMAN  |  |  | ANNIE LEON   |  |  |  |  |  |  |  |  |   |  |  |                                |  |  |                                |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)   |  |  | 17. INFORMANT ADDRESS  |  |  |  |  |  |   |  |  |                                |  |  |                                |  |  |
| YES  |  |  | WWII-NAVY  |  |  | 216-09-9327  |  |  | MRS. ZELDA FRIEDMAN  |  |  | 3012 FALLSTAFF RD., APT. D  |  |  | #21209                         |  |  |                                |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  | 19. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |                                |  |  |                                |  |  |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |                                |  |  |                                |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) 3 Acute Myo Infart?   |  |  |  |  |  |  |  |  |  |  |  |   |  |  |                                |  |  |                                |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD.  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |                                |  |  |                                |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                 |  |  |  |  |  |  |  |  |  |  |  |   |  |  |                                |  |  |                                |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |  |  |   |  |  |                                |  |  |                                |  |  |
|  |  |  | P.M. 19  |  |  |  |  |  |  |  |  |   |  |  |                                |  |  |                                |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |   |  |  |                                |  |  |                                |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |                                |  |  |                                |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from above, (I) (we) did not view the body after death.                              |  |  | 22b. SIGNATURE   |  |  | 22c. ADDRESS   |  |  | 22d. DATE SIGNED   |  |  |   |  |  |                                |  |  |                                |  |  |
|  |  |  | MD   |  |  | SHAR HOSPITAL  |  |  | 11/2/80  |  |  |   |  |  |                                |  |  |                                |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  | 23b. DATE  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |  |   |  |  |                                |  |  |                                |  |  |
| BURIAL   |  |  | NOV. 3, 1980   |  |  | SHAAREI TFILOH   |  |  | BALTIMORE  |  |  | MARYLAND  |  |  |                                |  |  |                                |  |  |
| 24. FUNERAL DIRECTOR NAME  |  |  | 24b. ADDRESS   |  |  | 25a. DATE REC'D. BY REGISTRAR  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |   |  |  |                                |  |  |                                |  |  |
| SOL LEVINSON & BROS., INC.   |  |  | 6010 REISTERSTOWN RD. BALTO. MD 21215  |  |  | NOV 5 1980   |  |  | Ricky H. H. H.   |  |  |   |  |  |                                |  |  |                                |  |  |

MEDICAL CERTIFICATION

99

69

42

35

300

1

1

1

1

1

1

1

1

1

1

1

1

1

101

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

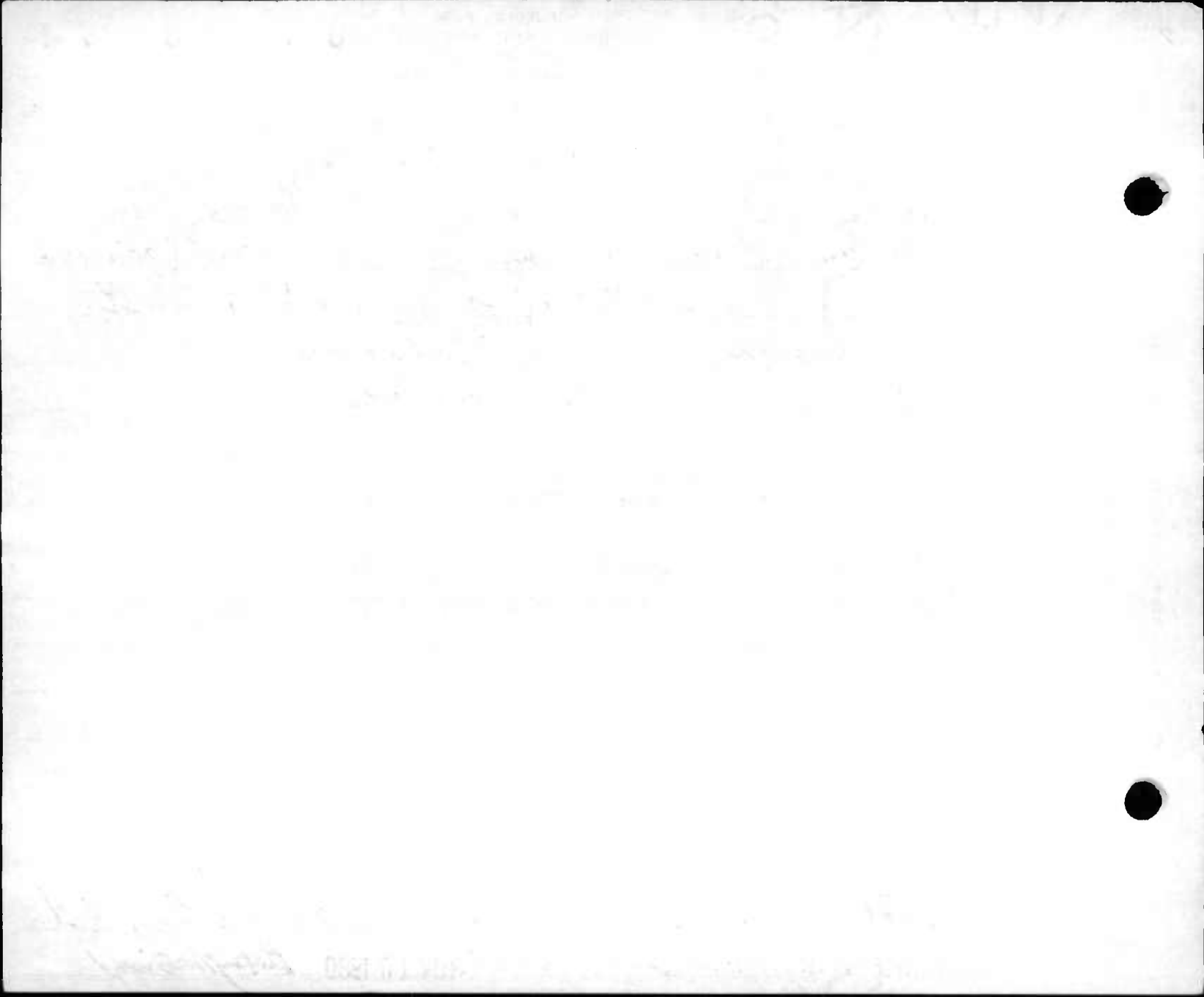
FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 0 6 4

REG. NO.

|  |  |   |  |   |  |  |                                     |   |   |
|--|--|---|--|---|--|--|-------------------------------------|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Joseph Frisch   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 1 80                         |   |  | 2b. HOUR<br>11:44 AM   |                                     |   |   |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>March ? 1894  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>86  |                                     | 7. UNDER 1 YEAR<br>MONTHS DAYS HOURS MINS   |   |
| 8a. BIRTHPLACE (STATE OR FOREIGN)<br>Md  |  | 8b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 9. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 10. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore, City MD  |                                     |   |   |
| 11. CITY OR TOWN OF DEATH<br>Baltimore   |  | 12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>Baltimore City Hosp. |  |   |  | 13a. USUAL OCCUPATION<br>Cigarette Maker   |                                     | 13b. KIND OF BUSINESS OR INDUSTRY<br>Railroad   |   |
| 14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>14a. STATE<br>Md  |  | 14b. COUNTY<br>Baltimore  |  | 14c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 14d. STREET ADDRESS<br>128 N. Janney St.   |                                     |   |   |
| 15. FATHER'S NAME<br>Unknown   |  |   | 16. MOTHER'S MAIDEN NAME<br>Unknown                                    |   |  | 17. INFORMANT<br>Edgar Stover  |                                     |   |   |
| 18a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, IF UNKNOWN)  |  |   | 18b. SOCIAL SECURITY NO.<br>717-07-7163                                |   |  | 19. ADDRESS  |                                     |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u><br>5188<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Lung disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>CONDITIONS, IF ANY, WHICH<br>GAVE RISE TO IMMEDIATE<br>CAUSE (a), stating the<br>underlying cause last |  |   |  |   |  |  |                                     |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |   |  |   |  |  |                                     |   |   |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                     | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                                     |   |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                                     |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last<br>saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |                                     |   |   |
| 22b. SIGNATURE<br>D. S. Ogel MD  |  |   | DEGREE   |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                     | 22c. DATE SIGNED  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>D. S. Ogel  |  |   | 22e. ADDRESS<br>Balt City Hosp   |   |  |  |                                     |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(CHECK)<br>Burial   |  |   | 23b. DATE<br>11.5.80   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Carmel |  | 23d. LOCATION<br>Baltimore City Md. |   |   |
| 24. FUNERAL DIRECTOR<br>Name<br>Helma A. Hoffmann  |  |   | ADDRESS<br>3218 Hudson St  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 10 1980   |                                     | 25b. REGISTRAR'S SIGNATURE<br>Ruthy Thibault  |   |







STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 28065

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |   |   |   |   |   |  |   |  |  |  |
|---|--|---|---|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>LEO H. FULTZ</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>7 NOV 3. 1980</b> |   | 2b. HOUR<br><b>11:10 AM</b>   |   |  |   |  |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 9 23</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>57</b> YRS<br>IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |  |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST AGNES HOSPITAL</b> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>First Fitter</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Maryland Ry &amp; Engr</b> |   |  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  |   |   | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                     |  | 13e. STREET ADDRESS<br><b>1613 Olive ST.</b>     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Lawrence FULTZ</b>   |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lelia House</b>   |   |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  |   |   | 16b. SOCIAL SECURITY NO.<br><b>217-14-9575</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Hilda Emerick 1721 Jackson ST.</b>                                      |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY ARREST</b><br><b>3481</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>RESPIRATORY ARREST CEREBRAL ANOXIA</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ASPHYXIA</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 min</b><br><b>4 DAYS</b><br><b>4 DAYS</b> |  |   |   |   |   |   |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>          |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>OCT. 31</b> , 19 <b>80</b> , to <b>NOV. 03</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>3 NOV</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>[Signature]</b>  |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   |   |  | 22c. DATE SIGNED<br><b>11-3-80</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. DECASTRO</b>  |  |   |   | 22e. ADDRESS<br><b>WILKENS &amp; CATON AVE. BALTO. MD 21229</b>   |   |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>11/5/80</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>                                     |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Charles L. Stevens</b>   |  |   |   | ADDRESS<br><b>Funeral Home, Inc. 1501 E. Fort Ave.</b>  |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 5 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b> |  |

MEDICAL CERTIFICATION

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

2302 BP

BALTIMORE CITY

ST. ANNE'S CHURCH

100-100

100-100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

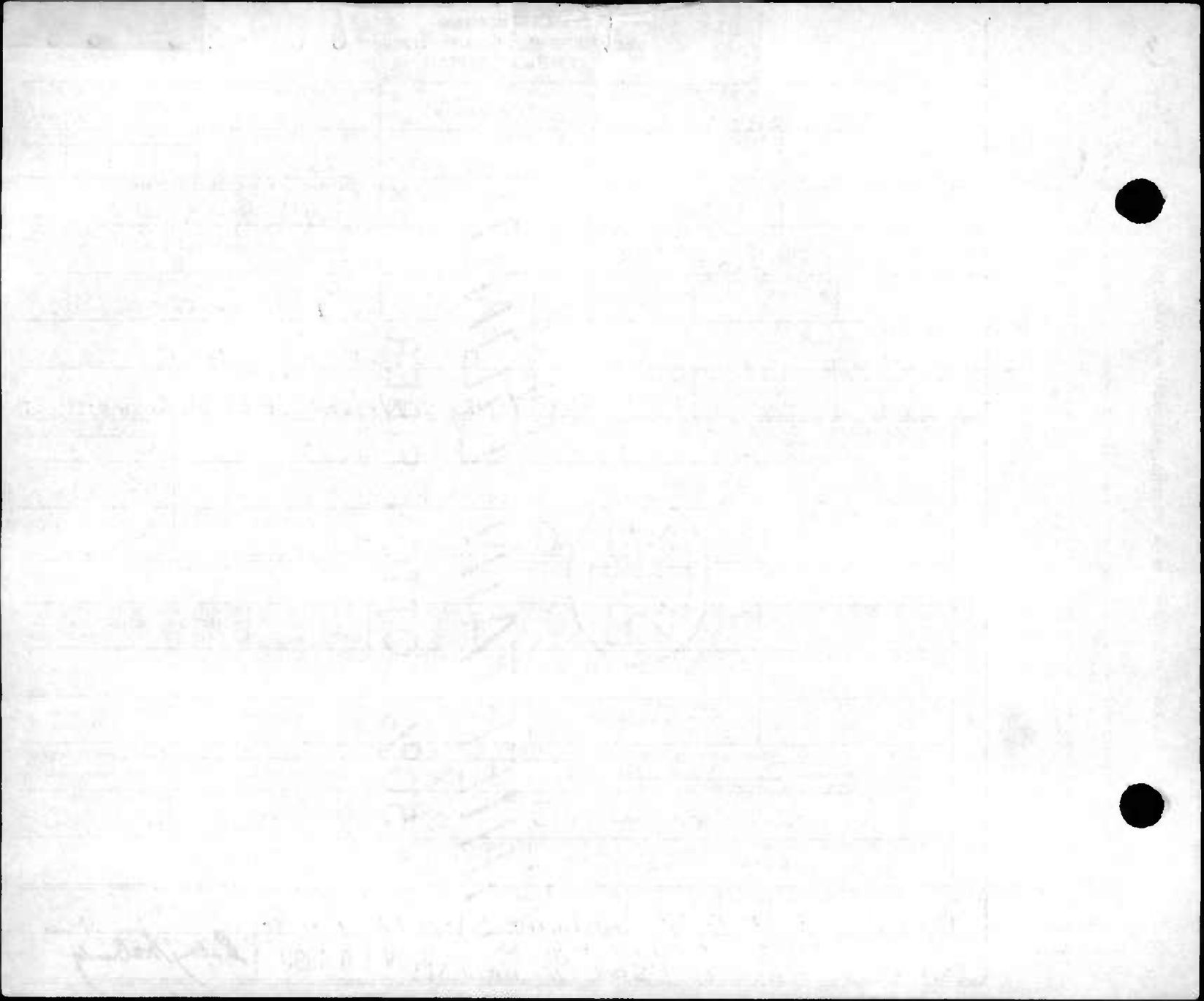
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |   |   |  |   |
|--|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Dora GARNER Funderburk   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 8 80  |  | 2b. HOUR<br>9:10 AM   |
| 3. SEX<br>F  | 4. RACE<br>B   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 04 04   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>76 YRS.                                     | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>N.C.  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balt. City MD.                         |   |
| 10. CITY OR TOWN OF DEATH<br>Balt. City  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>U. of Md. |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>unemployed                  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |   |  |   |
| 13a. STATE<br>Md.  | 13b. COUNTY  | 13c. CITY OR TOWN<br>Balt. City   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>1621 W. Lexington St.                                   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Joseph Nelson  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elizabeth Harper   |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>216-01-8387  | 17. INFORMANT<br>ADDRESS<br>HENRY S. Nelson 1621 W. Lexington St.                               |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardio-pulmonary arrest</u><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>cardiogenic shock</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>myocardial infarction</u>  |  |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>40 min's<br>30 hrs.<br>36 hrs.   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |   |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/6/80</u> 19 <u>80</u> , to <u>11/8</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>11/8/80</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |  |   |
| 22b. SIGNATURE<br>Jan Lewis Houghton MD  |  |   |   | 22c. DATE SIGNED<br>11/8/80  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Jan Lewis Houghton  |  |   |   | 22e. ADDRESS<br>U. of Md. Hosp.  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  | 23b. DATE<br>11-13-80   | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus MEM PR  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALT MD   |
| 24. FUNERAL DIRECTOR<br>NAME<br>ISAIAH L. BROWN & SON  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 10 1980  |  |   |
| 25b. FUNERAL DIRECTOR<br>ADDRESS<br>F/A W. BALT ST   |  |   | 25c. REGISTRAR'S SIGNATURE<br>R. H. Houghton  |  |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |  |  |
|---|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Nellie P. Gadd   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 14, 1980 |   |  | 2b. HOUR<br>M   |  |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6/20/1912   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>68 YRS.  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>South Baltimore Gen. Hospital |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife        |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Domestic  |  |  |
| 13a. STATE<br>Md.   |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Molie O. Garrett  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Addie Harper  |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>217-40-3584   |  | 17. INFORMANT<br>ADDRESS<br>Mrs. Donald E. Conrad Pasadena, Md. 21122<br>755 214th St.  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pulmonary edema</u><br>4149<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Coronary artery disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ |  |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> 19 <u>1960</u> , to <u>Nov 7</u> 19 <u>1980</u> that (I) (we) last saw the deceased alive on <u>Nov 7</u> 19 <u>1980</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>A.R. Sosnowski</u>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |   | 22c. DATE SIGNED<br>11/17/80   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>A.R. Sosnowski   |  |  |  | 22e. ADDRESS<br>4016 Ritchie Hwy Balto-21225  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>11/18/1980  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Glen Haven Mem. Pk.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Glen Burnie, A.A. Co., Md.                        |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Mcully Funeral Home   |  |  |  | 24b. ADDRESS<br>Balt. Md., 21225<br>237 E. Patapsco Ave.,   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 19 1980  |  | 25b. REGISTRAR'S SIGNATURE<br><u>L. J. Hardy</u> |  |

SECRET COLLECTION



#1, 549 11/18/80 bal  
 1-23 to 23 cand D G 549 11/18/80  
 STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 REGISTRAR GB CERTIFICATE OF DEATH 8 0 2 8 0 6 8  
 REG. NO.

|  |  |   |  |  |   |  |  |  |  |  |
|--|--|---|--|--|---|--|--|--|--|--|
| 1. DECEASED (NAME)<br>(TYPE OF PERSON)<br><b>John (Johnnie) Gibson</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 12 80</b> |  |   | 2b. HOUR<br><b>8:35 AM</b>   |  |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 8 15</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b> YRS.  |  | 7. UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.        |  |  |
| 7a. BIRTHPLACE (CITY OR TOWN)<br><b>St. Louis</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD                           |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>City</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Lutheran Hospital</b> |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE, INDUSTRY, OR MOST COMMON EMPLOYMENT)<br><b>Pipe Fitter</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b> |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br><b>Md.</b> |  |   | 13c. CITY OR TOWN<br><b>City</b>                       |  | 13d. STREET ADDRESS<br><b>703 Ashburton St.</b> |  |  |  |  |  |
| 14. FATHER'S NAME<br><b>Jessie</b>   |  |   | 15. MOTHER'S NAME<br><b>Lula</b>                       |  | 16. ADDRESS<br><b>2827 Windsor Ave.</b>         |  |  |  |  |  |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |   | 17b. SOCIAL SECURITY NO.<br><b>249-180094</b>          |  |   | 17c. INFORMATION<br><b>Mrs. Nedra Gibson</b>   |  |  |  |  |

|   |  |  |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Catall carcinoma of the lung</b><br>1629<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|--|--|

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (a) (this hospital) attended the deceased from <b>10/22/80</b> 19 to <b>11/12/80</b> 19, that (b) (we) last saw the deceased alive on <b>11/12/80</b> 19, and that in (c) (my) (our) opinion death occurred on the date and hour and from the causes stated above; (d) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Kyaw Nyunt</b>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11/12/80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KYAW NYUNT</b>   |  |  |  | 22e. ADDRESS<br><b>LUTHERAN HOSPITAL</b>   |  |  |  |

|  |  |                              |  |   |  |  |  |
|--|--|------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b> |  | 23b. DATE<br><b>11/17/80</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Memorial Park</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto Md.</b> |  |
|--|--|------------------------------|--|---|--|--|--|

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leroy Dyer &amp; Son</b> |  | ADDRESS<br><b>4600 Liberty Heights Blvd.</b> |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 14 1980</b> |  | 25b. REGISTRAR'S SIGNATURE<br><b>Henry M. Mundy</b> |  |
|---|--|--|--|---|--|---|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.







STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 28069

FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |   |  |  |   |
|---|--|--|---|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>SMITH</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 20, 1980</b> |   |  | 2b. HOUR<br><b>05:16PM</b>   |   |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Negro</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 23 00</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b>   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>GA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |   |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Chandler</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Annie Rucker</b>   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>  |  |  |   |
| 16b. SOCIAL SECURITY NO.<br><b>218-01-2868</b>  |  | 17. INFORMANT ADDRESS<br><b>Mary E. Gaines 1527 N. Monroe St.</b>  |   |   |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio pulmonary Arrest</b><br><b>5324</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>LOW CIRCULATING RED CELL MASS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Bleeding from Duodenal Ulcer.</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5:16PM 11/20/80</b><br><b>11/12/80</b> |  |  |   |   |  |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/15</b> , 19 <b>80</b> , to <b>11/20</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>11/20</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |   |  |  |   |
| 22b. SIGNATURE<br><b>Mr. Hausknecht</b>   |  |  |   | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>11-20-80</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HAUSKNECHT</b>  |  |  |   | 22e. ADDRESS<br><b>JOHNS HOPKINS HOSPITAL</b>   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>11/26/80</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore MD</b>  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>   |  |  |   | ADDRESS<br><b>1101 E. North Ave.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 25 1981</b>  |   |
|   |  |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |  |   |

49  
33  
300  
1  
2  
9  
1

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

Handwritten text at the top of the page, possibly a title or header.



Handwritten signature or name in the bottom left corner.

WOLFSBACH

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 0 7 0

FOR  
1- STATE  
REGISTRAR

REG. NO.

|   |   |   |   |  |  |
|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>GLASCOE C. GAITHER   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11-12-80   |  | 2b. HOUR<br>6:20AM   |
| 3. SEX<br>Male  | 4. RACE<br>Black  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>May 7, 1910   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>70 YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Church-Home-Hospital | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Trackman  | 12b. KIND OF BUSINESS OR INDUSTRY<br>B&O-Railroad   |  |  |
| 13a. STATE<br>Maryland  | 13b. COUNTY<br>Anne Arun.   | 13c. CITY OR TOWN<br>Dorsey   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br>7131 Wright Road-21076  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Rudolphus Gaither   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Cora Mack  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) No                         |  |  |
| 16b. SOCIAL SECURITY NO.<br>705-07-4801   |   | 17. INFORMANT<br>ADDRESS 7131 21076<br>Mrs. Gladys V. Gaither Wright Rd.  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 1629<br>DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA OF THE LUNG WITH METASTASIS<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |   |   |   |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-12-80 to 11-12-80, that (I) (we) last saw the deceased alive on 11-12-80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |   | 22b. SIGNATURE<br>V. Balakrishnan   |   | 22c. DATE SIGNED<br>11-12-80   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. V. BALAKRISHNAN, MD.   |   | 22e. ADDRESS<br>CHURCH HOSPITAL CORPORATION<br>100 N. BROADWAY BALTIMORE, MD. 21201   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  | 23b. DATE<br>11/17/80   | 23c. NAME OF CEMETERY OR CREMATORY<br>Saints Rest Cemetery  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Harmans, Maryland                      |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Herbert E. Nutter-3035 W. North Ave.  |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 13 1980  |   | 25b. REGISTRAR'S SIGNATURE   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 2 8 0 7 1  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>PAUL GALE</b>   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 21 80</b>  |  | 2b. HOUR<br><b>8:15P</b> M  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>BLACK</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 15 93</b>   |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  | 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VETERANS ADMINISTRATION MEDICAL CENTER</b>  |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>fireman</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>brick co.</b>   |  | 13a. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 13b. STREET ADDRESS<br><b>904 Lake Street</b>  |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOHN GALE</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>FLORENCE PRICE</b>  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>214 10 9849</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>VAMC Clinical Records Balto., Md. 21218</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>septic shock</b><br>6000<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>urinary tract infection</b><br>5d<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>benign prostatic hypertrophy</b><br>24n<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Diabetes</b>   |  |   |  |   |  |
| 19a. DATE OF OPERATION<br><b>none</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>none</b>   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  | 22a. I certify that (I) (this hospital) attended the deceased from <b>NOVEMBER 19, 19 80</b> , to <b>NOVEMBER 21, 19 80</b> , that (I) (we) last saw the deceased alive on <b>NOVEMBER 21, 19 80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |
| 22b. SIGNATURE<br><b>Andrew P. Fridberg MD</b>   |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>11/21/80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ANDREW FRIDBERG MD</b>   |  | 22e. ADDRESS<br><b>3900 Loch Raven Blvd. Balto., Md. 21218</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SEE CITY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>11/28/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GREEN ACRES MEM. PK</b>  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>SALISBURY WICOMICO MD</b>   |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>JOLLEY MEMORIAL CHAP. SALISBURY, MD.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 25 1980</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |   |  |   |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

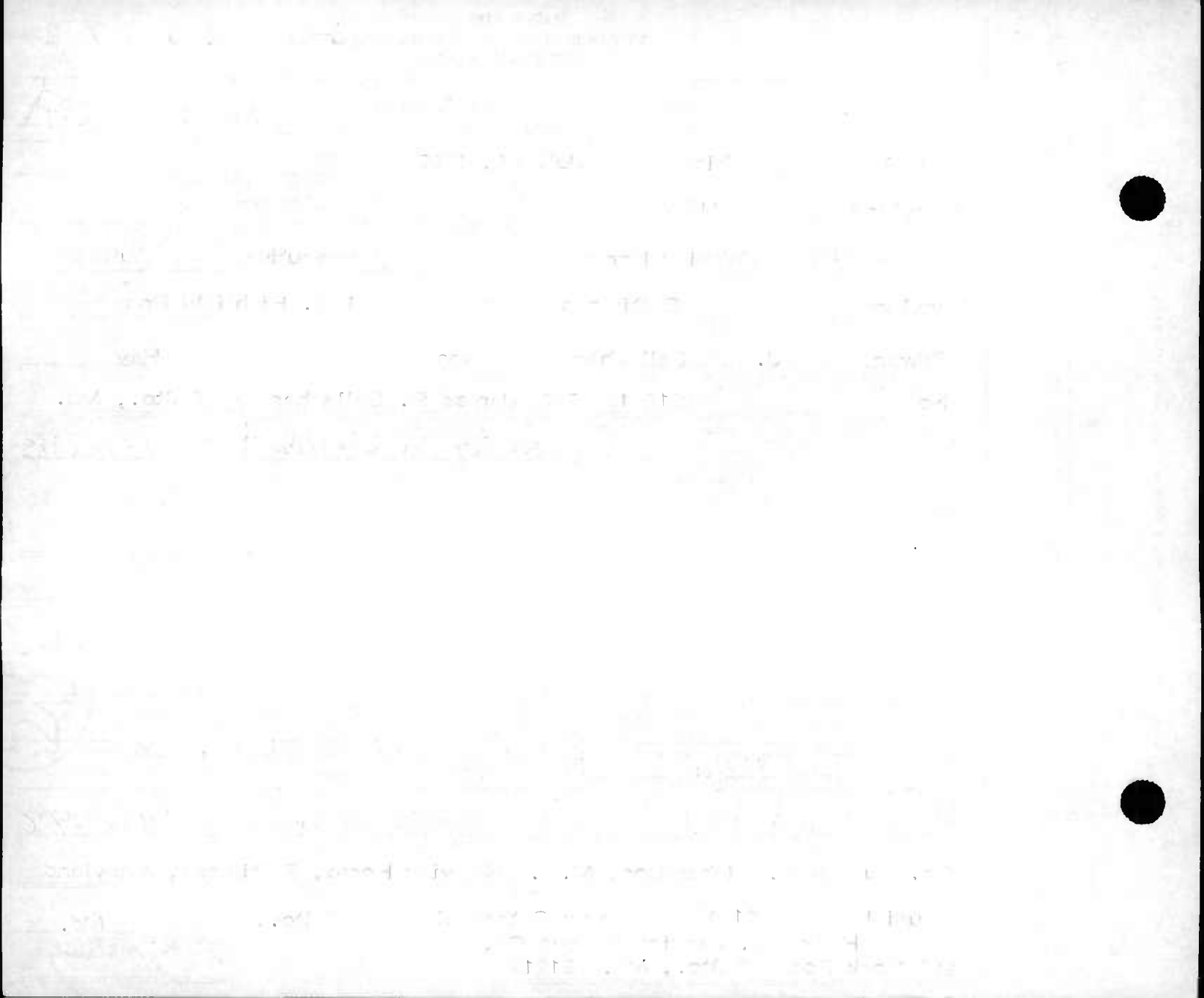
8-0

28072

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |  |  |  |  |
|--|--|---|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>A. <b>Norman Gallagher</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Nov 11 1980</b> |  |  | 2b. HOUR<br><b>2:58</b> M  |  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 31, 1897</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b> YRS                                     |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                    |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore City</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Keswick Home</b> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Executive</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Builder</b>  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Edward J. Gallagher</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ann Hay</b>   |   | 13e. STREET ADDRESS<br><b>1 E. Highfield Road</b>                                    |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>216 12 8765</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>James P. Gallagher Balto., Md.</b>                    |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b><br><b>4360</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>13 months</b>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____   |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>8 Nov 79</b> to <b>11 Nov 80</b> , that (1) (we) lost saw the deceased alive on <b>11 Nov 79</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.  |  |   |   |  |  |  |  |
| 22b. SIGNATURE<br><b>Dr. Aubrey D. Richardson</b>  |  |   |   | DEGREE<br><b>M.D.</b>  |  | 22c. DATE SIGNED<br><b>11 Nov 1980</b>   |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Aubrey D. Richardson, M.D.</b>   |  |   |   | 22e. ADDRESS<br><b>Keswick Home, Baltimore, Maryland</b>                             |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11/14/80</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral</b>                           |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto., Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Henry W. Jenkins &amp; Sons Co.</b><br>ADDRESS<br><b>4905 York Road Balto., Md. 21212</b>   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 12 1980</b>                                  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Barry McCreedy</b>  |  |





0908 BP  
DHMH-16 30M 2/80  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |   |   |   |                             |  |  | 80 28073   |  |
|--|--|---|--|---|---|---|-----------------------------|--|--|--|--|
| 1. STATE REGISTRAR   |  |   |  |   |   |   |                             |  |  | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>JOHN GARRISON</b>  |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Nov 2 80</b>        |   | 2b. HOUR<br><b>745 P.M.</b> |  |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Negro</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 1 06</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b>  |                             | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  | IF UNDER 74 HRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>   |                             |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |                             | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                             | 13e. STREET ADDRESS<br><b>719 E. 21st. St.</b>   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John W. Garrison Sr.</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Katie</b> |   |                             |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>220-03-5238</b>  |  | 17. INFORMANT ADDRESS<br><b>Monica Garrison Mayers 3237 Westmount Ave</b>   |   |   |                             |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CEREBROVASCULAR ACCIDENT</b>   |  |   |  |   |   |   |                             |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 WK.</b> |  |
| 4292<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>A S C V D</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |   |  |   |   |   |                             |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Peripheral Vascular Disease</b>  |  |   |  |   |   |   |                             |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                             | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>11/2/80</b><br>P.M.   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |                             |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |                             |  |  |  |  |
| 22a. I certify that (he/she) attended the deceased from <b>10/17/80</b> , 19____, to <b>11/2/80</b> , 19____, that (I) (we) lost<br>saw the deceased alive on <b>11/2/80</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |  |   |  |   |   |   |                             |  |  |  |  |
| 22b. SIGNATURE<br><b>SERIALD WARD</b>  |  |   |  |   |   | DEGREE<br><b>ATTENDING PHYSICIAN</b> <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                             | 22c. DATE SIGNED<br><b>2-NOV-86</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SERIALD WARD</b>   |  |   |  |   |   | 22e. ADDRESS<br><b>UNION MEMORIAL HOSPITAL</b>  |                             |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11/8/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Mem. Pk.</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co. MD</b>   |                             |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>  |  |   |  |   |   | ADDRESS<br><b>1101 E. North Ave.</b>  |                             | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 5 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Richard M. Brady</b>        |  |

GARRISON

JOHN

BALTIMORE CITY

UNION MEMORIAL HOSPITAL

BALTIMORE

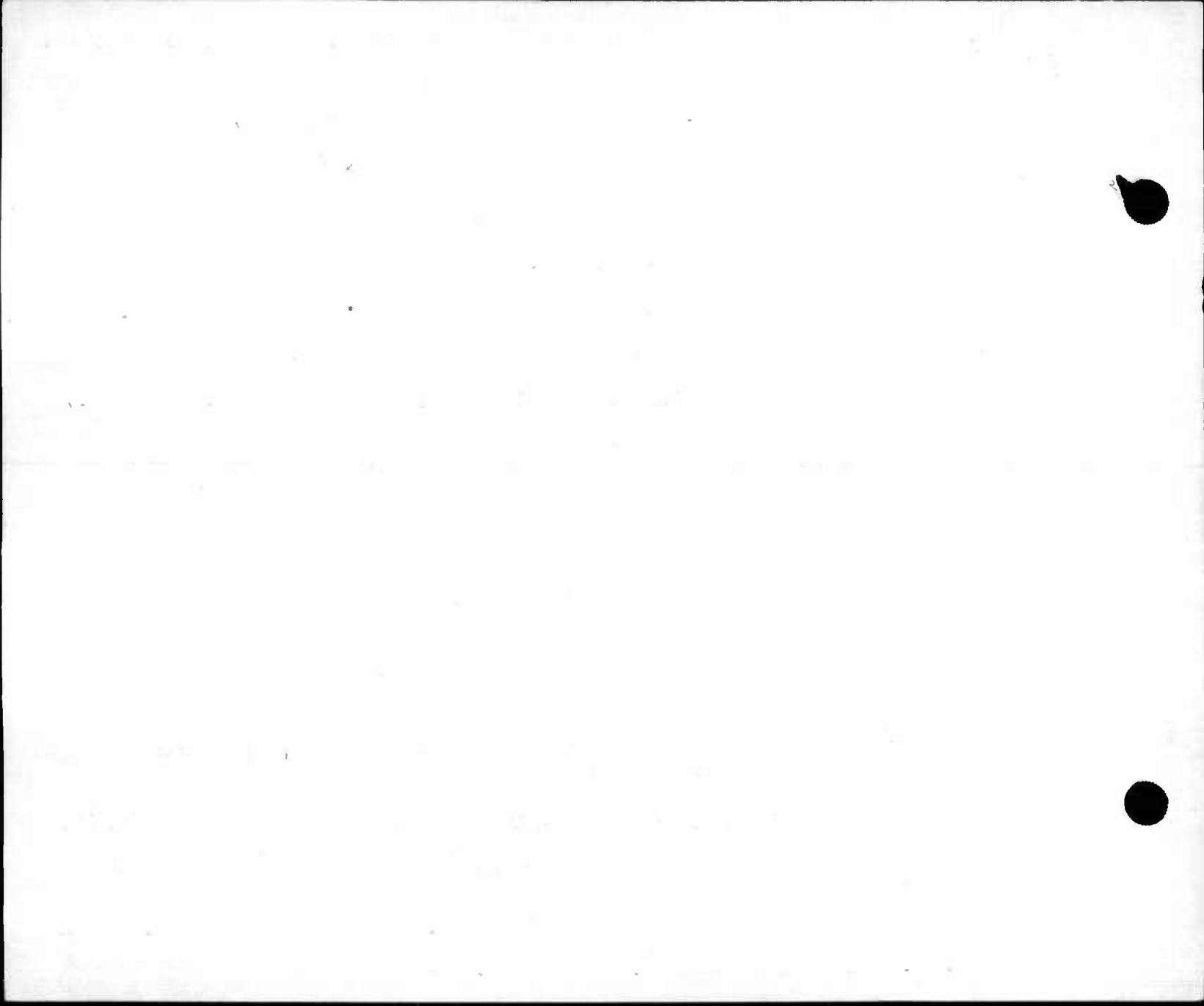
00012 VCH

**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

80 28074

REG. NO.

|   |  |  |  |  |   |
|---|--|--|--|--|---|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  | 2b. HOUR                                     |   |
| 1 DECEASED NAME FIRST MIDDLE LAST<br>KATIE M. GARY  |  | November 9, 1980   |  | 8 P M  |   |
| 3. SEX<br>Female  | 4 RACE<br>Negro  | 5 DATE OF BIRTH MONTH DAY YEAR<br>5 14 31  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>49 YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN     |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VA   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |  |   |
| 10 CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1633 Carswell St. | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |
| 13a. STATE<br>MD  | 13b. COUNTY<br>Baltimore   | 13c. CITY OR TOWN<br>Baltimore   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            | 13e. STREET ADDRESS<br>1633 Carswell St.     |   |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>Peter Whitehurst  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Lillie W. Lynch   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |  |  |   |
| 16b. SOCIAL SECURITY NO.<br>227-30-7504   | 17 INFORMANT ADDRESS<br>Lillie W. Ruffin 1520 N. 30th St., VA  |  |  |  |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma of Small Bowel</u><br>1529<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |  |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>Gastrointestinal Bleed</u>  |  |  |  |  |   |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6</u> 19 <u>79</u> , to <u>10/9</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>10/20</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                      |  |  |  |  |   |
| 22b. SIGNATURE<br><u>Davis M. Hahn</u>  | DEGREE<br>MD   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               | 22c. DATE SIGNED<br>11/10/80   |  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Davis M. Hahn  | 22e. ADDRESS<br>5801 Loch Raven Blvd 21237   |  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   | 23b. DATE<br>11/15/80  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cem.  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Co. MD   |  |   |
| 24 FUNERAL DIRECTOR NAME<br>Wm. C. March F/H  |  | ADDRESS<br>1101 E. North Ave.  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 10 1980 | 25b. REGISTRAR'S SIGNATURE<br><u>D. H. Hahn</u> |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

5

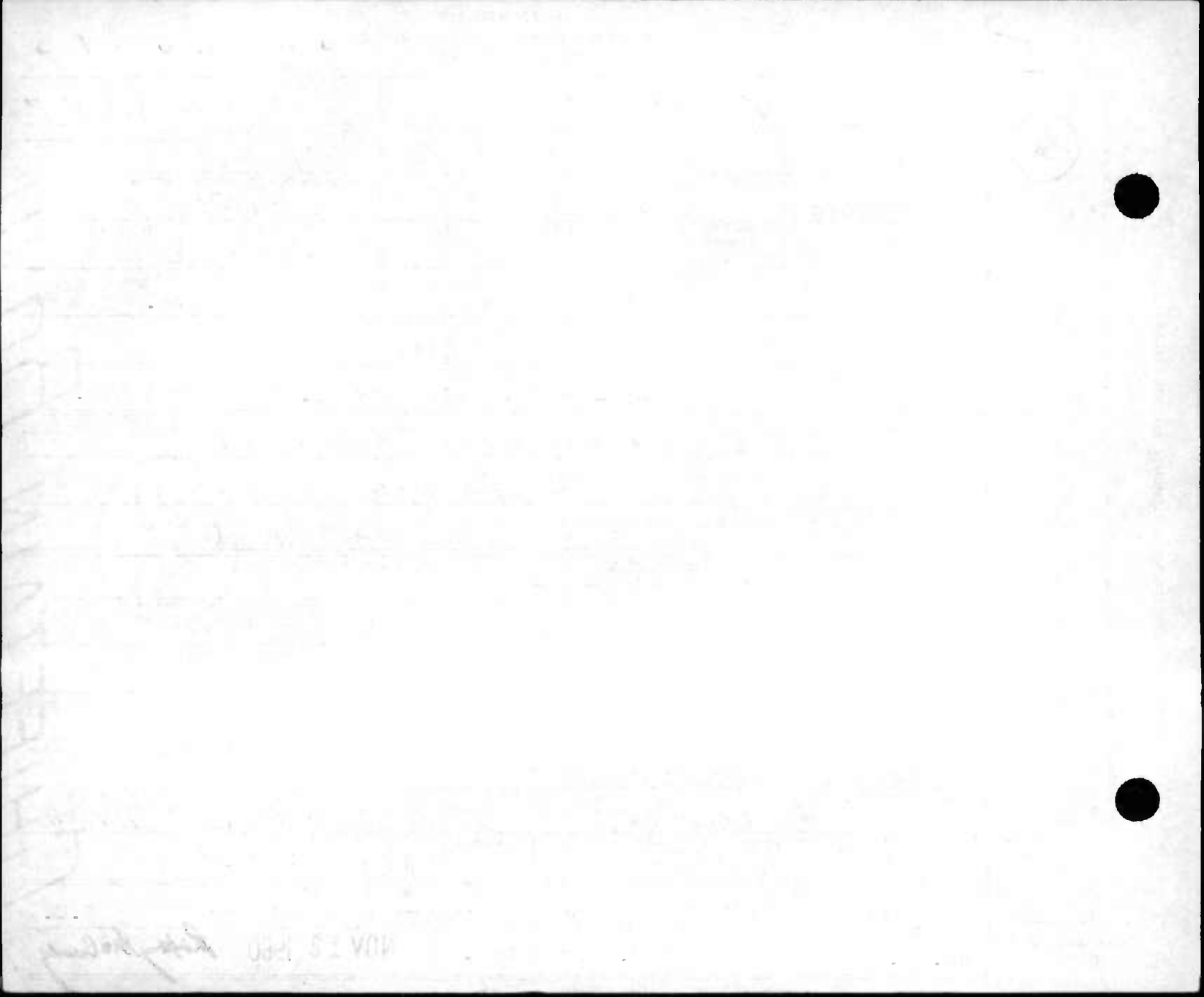
1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 0 7 5

REG. NO.

|  |                     |  |  |   |  |
|--|---------------------|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MATTIE M GARY</b>   |                     |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 10 80</b>       |   | 2b. HOUR<br><b>11 P</b>  |
| 3. SEX<br><b>F</b>   | 4. RACE<br><b>B</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 2 09</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S-CAROLINA</b>   |                     | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US</b>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MERCY HOSP</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>            |  |
| 13a. STATE<br><b>MD</b>  |                     | 13b. COUNTY  | 13c. CITY OR TOWN<br><b>Baltimore</b>                        | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>2626 Beryl Ave.</b>  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Ed Suber</b>  |                     | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Dollie Shears</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |                     | 16b. SOCIAL SECURITY NO.<br><b>219-18-4663A</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Jessie Gary Sr. 2626 Beryl Ave.</b>                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>5168</b> IMMEDIATE CAUSE (a) <b>STAPHYLOCCAL BACTEREMIA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>PNEUMONIA</b><br>(c) <b>DIFFUSE INTERSTITIAL PNEUMONITIS</b> |                     |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>C.H.F.</b>   |                     |  |  |   |  |
| 19a. DATE OF OPERATION   |                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |                     | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                     | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/6/80</b> to <b>11/10/80</b> , that (I) (we) last saw the deceased alive on <b>11/10/80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.)  |                     |  |  |   |  |
| 22b. SIGNATURE<br><b>K.C. Kung</b>   |                     | DEGREE<br><b>M.D.</b>  |  | 22c. DATE SIGNED<br><b>11/11/80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>K.C. Kung</b>  |                     | 22e. ADDRESS<br><b>Mercy Hosp.</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |                     | 23b. DATE<br><b>11/15/80</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Church Cemetery</b> |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Newsberry S.C.</b>  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>  |                     |  | ADDRESS<br><b>1101 E. North Ave.</b>                         |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 12 1980</b>  |
|  |                     |  | 25b. REGISTRAR'S SIGNATURE<br><b>Harry McBrady</b>           |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |   |   |   |  |   |  |
|--|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>JOY H. GATTIS   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>NOVEMBER 30, 1980                      |  | 2b. HOUR<br>02:03 PM  |  |
| 3. SEX<br>Female   | 4. RACE<br>White  | 5. DATE OF BIRTH<br>Feb. 26, 1940   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>40  |   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Texas  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                           |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br>Maryland   |   |   | 13b. COUNTY<br>Baltimore  | 13c. CITY OR TOWN<br>Timonium  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Coy B. Henson  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ellen Allyn Simmons          |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |   | 16b. SOCIAL SECURITY NO.<br>455-66-6633   |   | 17. INFORMANT<br>ADDRESS<br>Mr. William E. Gattis same as # 13                       |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) BRAIN DEATH<br>DUE TO, OR AS A CONSEQUENCE OF (b) Malignant brain tumor + hemiswelling<br>DUE TO, OR AS A CONSEQUENCE OF (c) 1919   |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 days  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |   |   |  |   |  |
| 19a. DATE OF OPERATION<br>11/26/80   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Brain Tumor   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |   |   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/30/80 to 11/30/80, that (I) (we) last saw the deceased alive on 11/30/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. |   |   |   |  |   |  |
| 22b. SIGNATURE<br>Ronald L. Cohen M.D.   |   | DEGREE<br>M.D.  |   | 22c. DATE SIGNED<br>11/30/80   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Ronald Cohen  |   | 22e. ADDRESS<br>Johns Hopkins Hospital  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation  |   | 23b. DATE<br>12/2/80  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Crematory                          |   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland   |   |   |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>Ruck Towson Funeral Home, Inc.   |   | 25a. DATE REC'D. BY REGISTRAR<br>DEC 3 1980   |   | 25b. REGISTRAR'S SIGNATURE<br>Ricky Melnyk   |   |  |

BP

110



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 28077

REG. NO.

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  | 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>JOHN J. GEDEON   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>11-9-80  |  | 2b. HOUR<br>2:15AM  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>1 29 1928   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS<br>52   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Ohio   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Church Hospital Corporation   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Bartender   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Manny's Cafe   |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>James Gedeon   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Elizabeth Gaydosh   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO. A<br>217-22-8602   |  |
| 17. INFORMANT<br>Katherine Tagliamburis   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) REFRACTORY VENTRICULAR FIBRILLATION<br>4149<br>DUE TO, OR AS A CONSEQUENCE OF (b) ISCHEMIC HEART DISEASE<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>PRESUMED PULMONARY EMBOLI, PNEUMONIA, DIABETES MELLITUS  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) this hospital attended the deceased from 11-9-80 to 11-9-80, that (I) we last saw the deceased alive on 11-9-80, and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did/did not) view the body after death. |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br>DR. DAVID BUSH, MD.   |  | DEGREE<br>MD  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  | 22c. DATE SIGNED<br>11-9-80   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. DAVID BUSH, MD.  |  | 22e. ADDRESS<br>100 N. BROADWAY BALTIMORE, MD.  |  | 22f. CITY OR TOWN<br>BALTIMORE   |  | 22g. STATE<br>MD.   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>11/11/80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Oak Lawn Cemetery  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore, MD  |  |
| 24. FUNERAL DIRECTOR NAME<br>Duda-Ruck, Inc.  |  | 24b. ADDRESS<br>7922 Wise Avenue, Dundalk, MD 21222   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 12 1980   |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

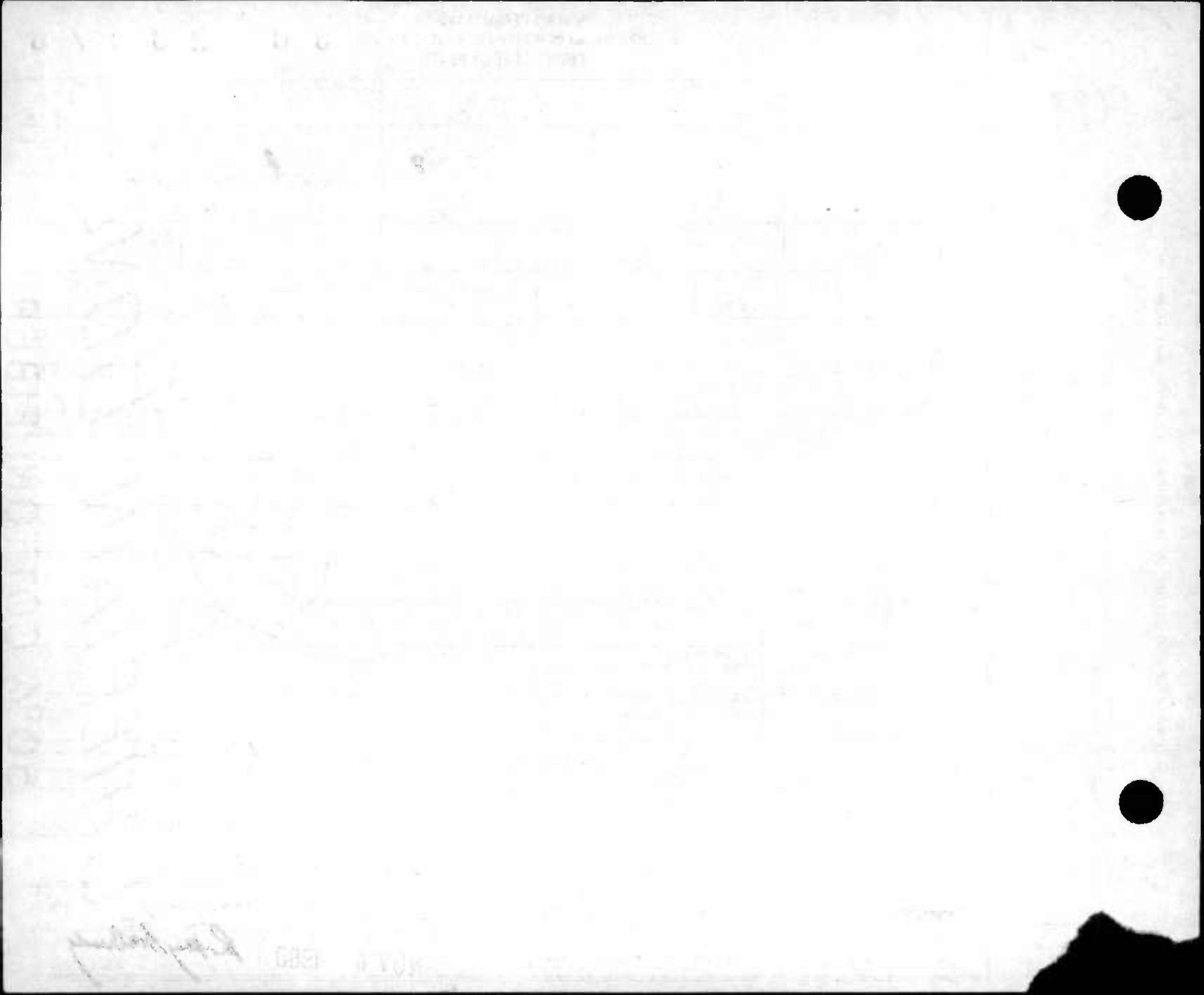
FORM 2/80

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 28078

REG. NO.

|   |  |   |  |  |  |  |  |  |  |
|---|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Clifton - George  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 5 80                         |  |  | 2b. HOUR<br>3 <sup>15</sup> / <sub>A</sub> M   |  |  |  |
| 3. SEX<br>M   |  | 4. RACE<br>B  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 17 92   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82 YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>S.C.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Mercy Hospital |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE Md. 13b. COUNTY Balto. 13c. CITY OR TOWN Balto.  |  |   |  |  |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Unkn  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Unkn                  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  |  |  |
| 16b. SOCIAL SECURITY NO.<br>705-03-9580   |  |   | 17. INFORMANT<br>Ernestine Wilson                                      |  |  |  | ADDRESS<br>E. Orange, N.J.<br>55 E. Park St.                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Pneumonia<br>4960<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (b) COPD<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |   |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/1/80, 19 80, to 11/5/80, 19 80, that (I) (we) last saw the deceased alive on 11/5/80, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.           |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>Jeffrey D. Gaber MD   |  |   | DEGREE<br>MD   |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>11/5/80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JEFFREY D. GABER   |  |   | 22e. ADDRESS<br>Mercy Hospital   |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation   |  |   | 23b. DATE<br>11/7/80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Mem. Pk.                        |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Catonsville, Md. |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm C March F/H  |  |   | ADDRESS<br>1101 E. North Ave.  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 6 1980  |  | 25b. REGISTRAR'S SIGNATURE<br>Ruthy K. Bundy   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

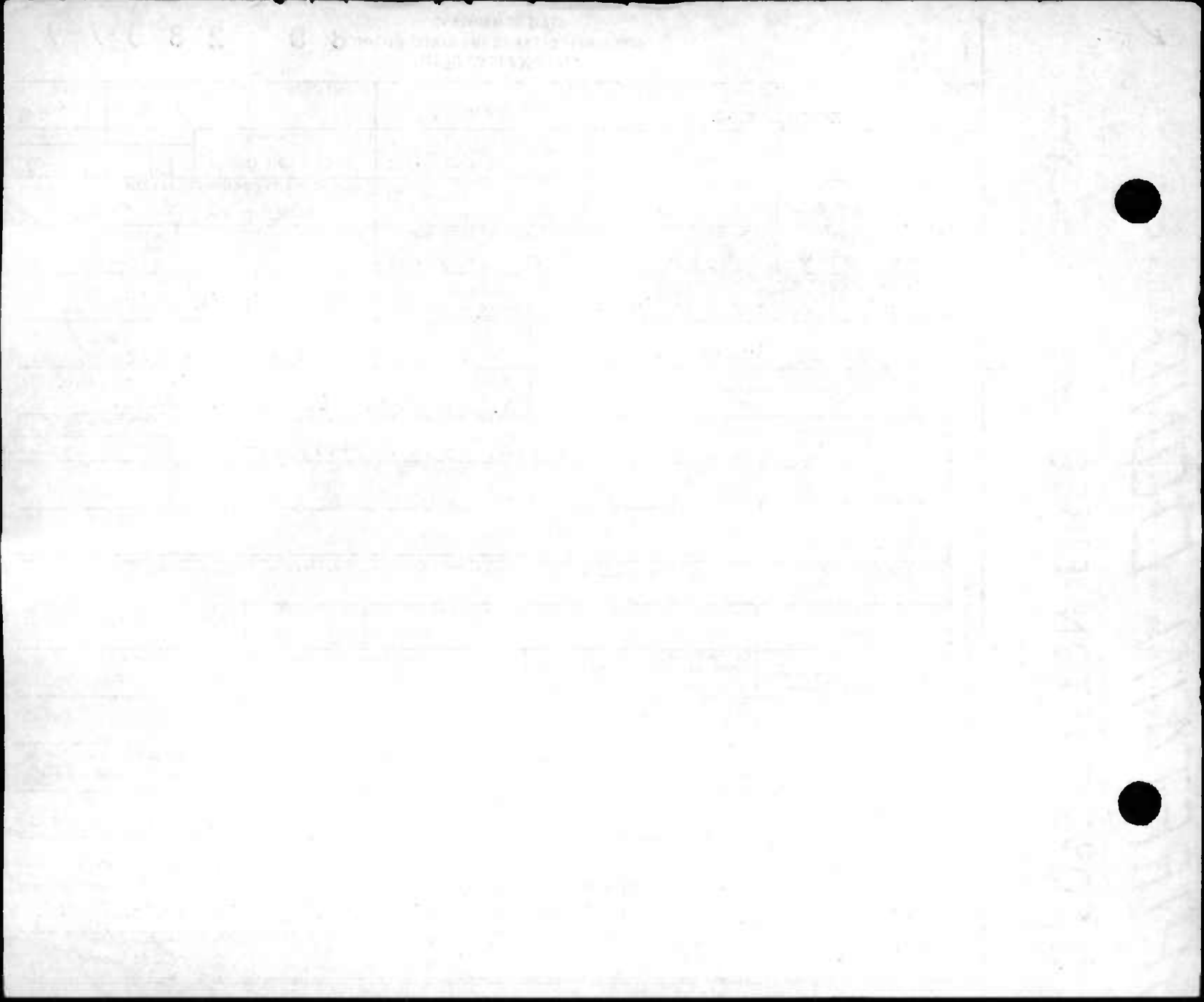
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

80 28079

|  |   |  |   |  |  |
|--|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST <u>STEPHEN</u> MIDDLE <u>MICHAEL</u> LAST <u>George</u><br><del>xxxxxx</del>  |   | 2a. DATE OF DEATH<br>MONTH <u>11</u> DAY <u>15</u> YEAR <u>80</u>  |   | 2b. HOUR<br><u>1:22 AM</u>   |  |
| 3. SEX<br><u>Male</u>  | 4. RACE<br><u>Wt</u>  | 5. DATE OF BIRTH<br>MONTH <u>11</u> DAY <u>14</u> YEAR <u>80</u>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>1 d. old</u> YRS <u>0</u> MONTHS <u>1</u> DAYS <u>1</u> HOURS <u>7</u> MIN |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>Md. USA</u>  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Baltimore City</u> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><u>Baltimore</u>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>Baltimore City Hospital</u> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>— |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>—       |
| 13a. STATE<br><u>Maryland</u>  |   | 13b. COUNTY<br><u>Harford</u>  | 13c. CITY OR TOWN<br><u>Abingdon</u>                                  | 13d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                  |  |
| 14. FATHER'S NAME<br>FIRST <u>Michael</u> MIDDLE <u>Avery</u> LAST <u>George</u>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <u>Cherie</u> MIDDLE <u>Ann</u> LAST <u>Johnson</u>  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>—  |   | 16b. SOCIAL SECURITY NO.<br>—  |   | 17. INFORMANT<br>ADDRESS <u>Abingdon, Md.</u><br><u>Mr. and Mrs. Michael A. George,</u>                          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u><br><u>7718</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Possible Neonatal Sepsis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) —<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) —  |   |  |   |  |  |
| 19a. DATE OF OPERATION<br>—  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>—  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br>—                              |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>—  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 14</u> , 19 <u>80</u> , to <u>Nov 15</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>Nov 15</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                           |   |  |   |  |  |
| 22b. SIGNATURE<br><u>Elien Roy Elias</u>   |   |  |   | 22c. DATE SIGNED<br><u>11/15/80</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Elien Roy Elias</u>  |   |  |   | 22e. ADDRESS<br><u>Baltimore City HOP, Balt, md.</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>   |   | 23b. DATE<br><u>Nov. 18, 1980</u>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Oak Grove Baptist Cem.</u>  |  |
| 23d. LOCATION (CITY OR TOWN)<br><u>Belt Air</u>  |   | 23e. COUNTY<br><u>Harford</u>  |   | 23f. STATE<br><u>MD.</u>   |  |
| 24. FUNERAL DIRECTOR<br><u>Howard K. McComas III,</u>  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><u>NOV 19 1980</u>  |  |
| 25b. ADDRESS<br><u>Abingdon, Md.</u>   |   |  |   | 25c. REGISTRAR'S SIGNATURE<br><u>Robert McCreedy</u>   |  |

BP.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMM-16 30M 2/80  
(VRA 15, 4)STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 0 8 0

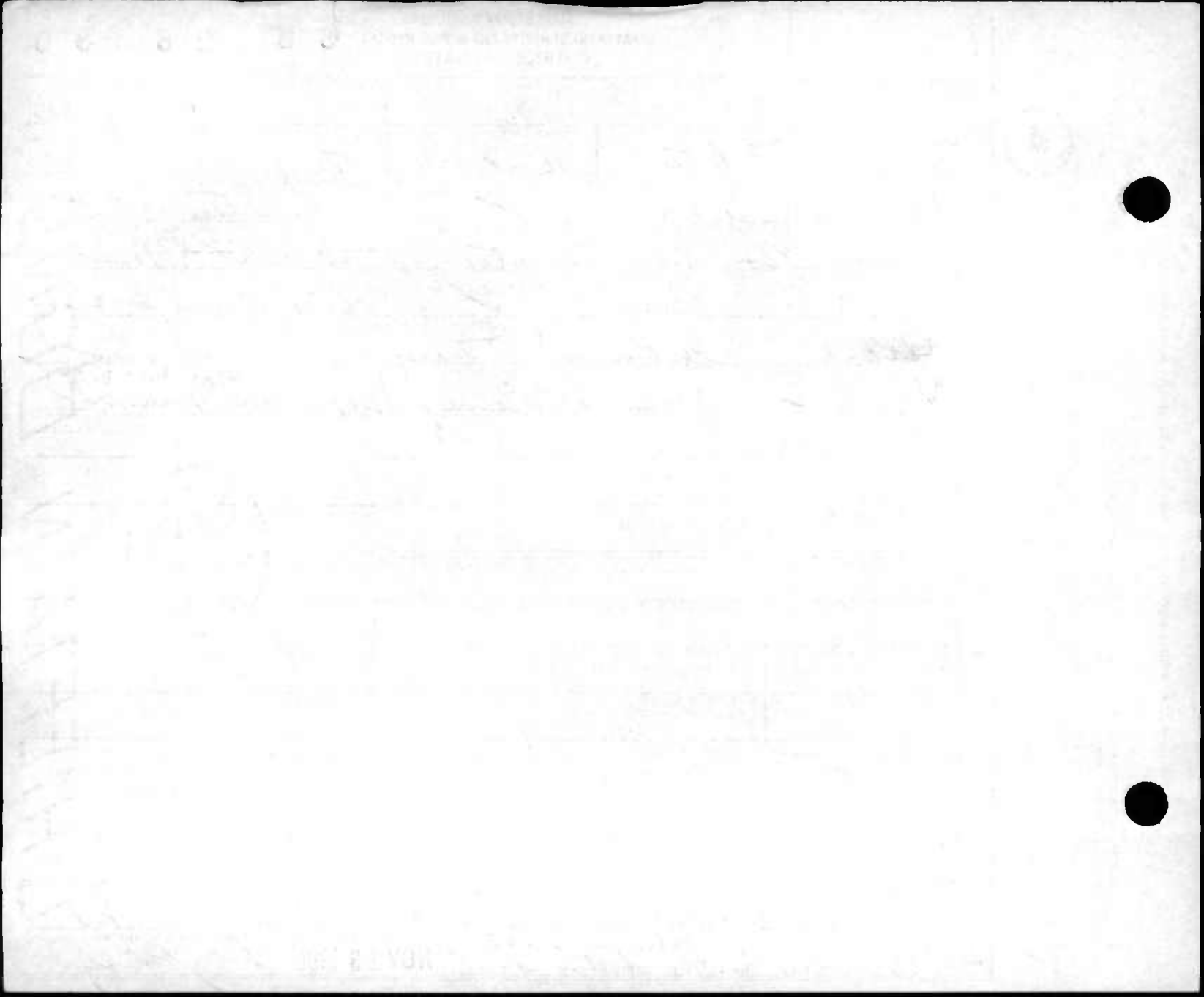
REG. NO.

1 - FOR  
STATE  
REGISTRAR

|   |   |   |   |  |  |
|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CATHERINE E GEPPi</b>  |   |   | 2a. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>10</b> YEAR <b>80</b> |  | 2b. HOUR<br><b>10.55 P.M.</b>                |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>                       | 5. DATE OF BIRTH<br>MONTH <b>10</b> DAY <b>8</b> YEAR <b>1910</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS. MONTHS <b>0</b> DAYS <b>0</b> HRS. <b>0</b> MINS. <b>0</b> |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Ind.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Bon Secours Hospital</b>                    |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Bar Owner</b>                         |  |
| 13a. STATE<br><b>Ind.</b>   |   | 13b. COUNTY<br><b>Balt.</b>   |   | 13c. STREET ADDRESS<br><b>861 W. Lombard St. 21201</b>   |  |
| 14. FATHER'S NAME<br>FIRST <b>Frank</b> MIDDLE <b>Gutmann</b> LAST <b>Gutmann</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Mary</b> MIDDLE <b>Simco</b> LAST <b>Simco</b>   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                            |  |
| 16b. SOCIAL SECURITY NO.<br><b>219-22-8685</b>  |   | 17. INFORMANT<br><b>Joseph M. 21085</b>   |   | ADDRESS<br><b>404 Harden Dr.</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CA of Right Kidney with metastases</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.        |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____   |   |   |   |  |  |
| 19a. DATE OF OPERATION<br><b>11/10/80</b>   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                         |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |   |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                               |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/29</b> , 19 <b>80</b> , to <b>11/10</b> , 19 <b>80</b> , that (I) (we) lost<br>saw the deceased alive on <b>11/10</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |   |   |   |  |  |
| 22b. SIGNATURE<br><b>Kuang-Yen Huang</b>  |   | DEGREE<br><b>M.D.</b>   |   | 22c. DATE SIGNED<br><b>11/11/80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KUANG-YEN HUANG</b>   |   | 22e. ADDRESS<br><b>BON Secours Hospital</b>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |   | 23b. DATE<br><b>11-14-1980</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greenwood Mem. Pl.</b>  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Ind.</b>   |   | 23e. DATE REC'D. BY REGISTRAR<br><b>NOV 13 1980</b>   |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>John J. Conner &amp; Son Inc.</b>  |   | ADDRESS<br><b>901 Fallers Dr.</b>   |   | 25a. REGISTRAR'S SIGNATURE<br><b>Anthony McCreedy</b>  |  |

MEDICAL CERTIFICATION

2  
9  
1





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 0 8 1

1 - FOR  
STATE  
REGISTRAR

REG. NO.

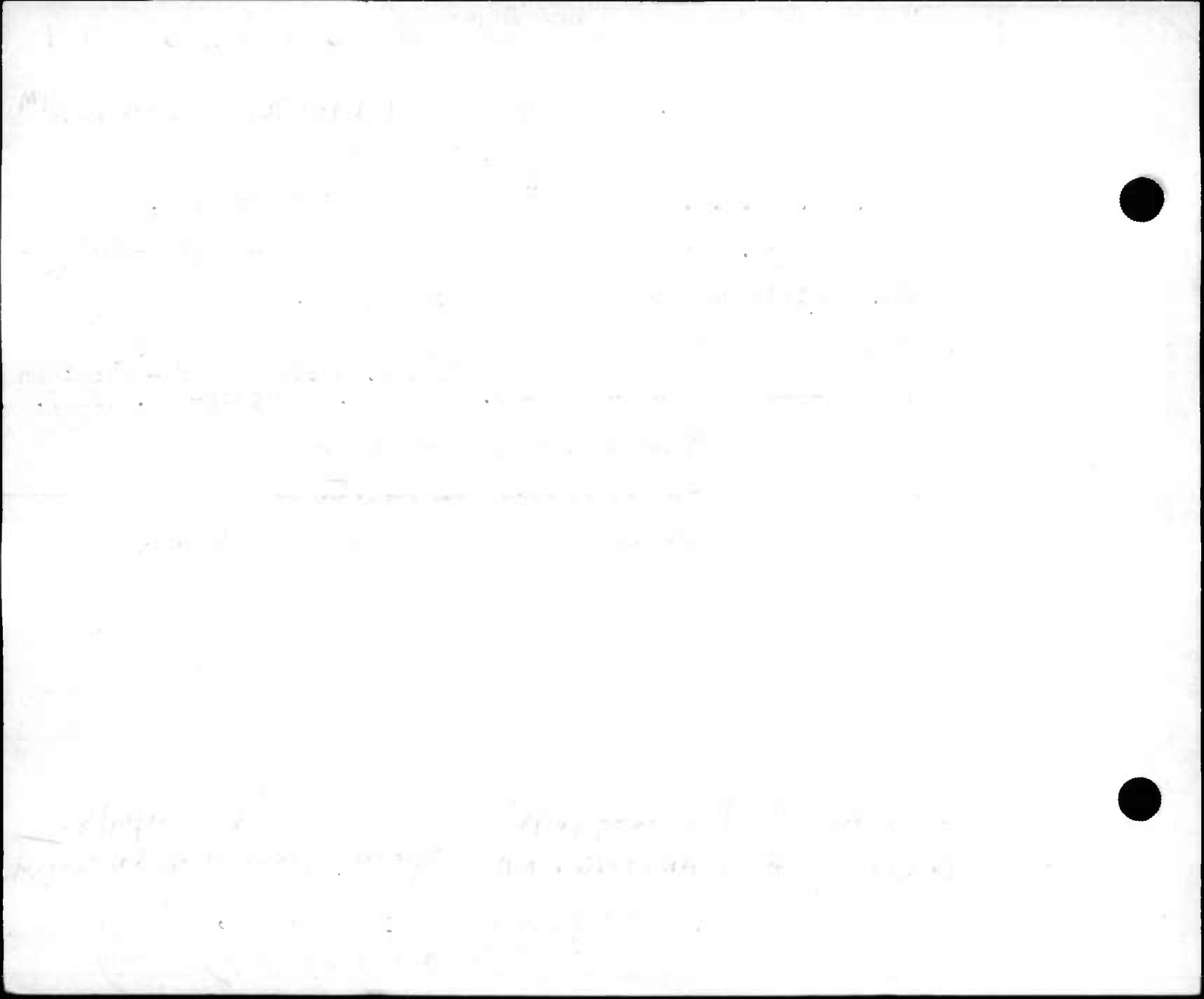
|   |   |  |   |  |  |
|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Marie E. Geraghty   |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11/13/80 11 13 1980                                      |  | 2b. HOUR<br>10:10 PM   |
| 3. SEX<br>Female  | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>June 22, 1897  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>83   | 7. UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                      |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Baltimore, Md.  | 9. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 11. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                                    |  |  |
| 12. CITY OR TOWN OF DEATH<br>Baltimore  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Agnes Hospital |  | 14. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Waitress-Cashier-Cafeter-    |  | 15. KIND OF BUSINESS OR INDUSTRY<br>ta   |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.  | 13b. COUNTY<br>Baltimore  | 13c. CITY OR TOWN<br>Woodlawn  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br>2106 N. Rolling Road                                    |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Joseph Huska  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elizabeth ?  |  | 16. ADDRESS<br>2106 N. Rolling Road - Woodlawn  |  |  |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  | 17b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>-----  | 17. INFORMANT<br>2106 N. Rolling Road - Woodlawn<br>Mr. Walter J. Geraghty - Md. 21207.  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Pulmonary embolism<br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial infarction<br>DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic cardiovascular disease |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |   |  |   |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |   |  |   |  |  |
| 22b. SIGNATURE<br>Dorothy B. Bandonick, MD  |   | DEGREE<br>MD   |   | 22c. DATE SIGNED<br>11/14/80   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dorothy B. Bandonick, MD   |   | 22e. ADDRESS<br>Spring Grove Hospital Center   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  | 23b. DATE<br>11/17/80   | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore National Cemetery  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland              |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Sterling Funeral Estate   |   | ADDRESS<br>736 Edmondson Ave.<br>Catonsville, Md. 21228  |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 18 1980                                   | 25b. REGISTRAR'S SIGNATURE<br>Dorothy B. Bandonick   |

BP  
DHMH-16 20M  
(VRA 15, 4) 7/78

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |   |  |  |  |  |  | 8 0 2 8 0 8 2  |  |
|---|--|---|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  | CERTIFICATE OF DEATH  |  |  |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>HAROLD HALCOM GIBBONS, JR.   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>11 20 80  |  |  |  | 2b. HOUR<br>1:30 PM  |  |  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>June 29, 1903  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>77 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                           |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Mechanical Engineer |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Federal Gov't.  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE COUNTY CITY OR TOWN<br>Maryland Baltimore  |  |   |  | 13b. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13c. STREET ADDRESS<br>418 E. Lake Ave.  |  |  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Harold Halcom Gibbons  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Lita Harris   |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>216-05-9468   |  | 17. INFORMANT<br>Mary Davy Gibbons  |  |  |  | ADDRESS<br>Same  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Metastatic carcinoma of the brain</u><br>1629<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Oat cell carcinoma of the lung</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>5 months</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) |  |   |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| 19a. DATE OF OPERATION<br>NONE  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/6</u> , 19 <u>80</u> , to <u>11/20</u> , 19 <u>80</u> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <u>11/20</u> , 19 <u>80</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input type="checkbox"/> (we) <input type="checkbox"/> (did not) view the body after death.  |  |   |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>James C Jarrell   |  |   |  | DEGREE<br>MD  |  |  |  | 22c. DATE SIGNED<br>11/20/80   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>James C Jarrell  |  |   |  | 22e. ADDRESS<br>Union Mem'l Hosp, Bldg. 4, MD 21218   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>Nov. 22, 1980  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Greenmount  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore City, Maryland                  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Mitchell-Wiedefeld Home, Inc.  |  |   |  | ADDRESS<br>6500 York Rd. Balto., Md.  |  | 25a. DATE REC'D BY REGISTRAR<br>NOV 25 1980  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |  |  |



STANDARD, INC.

June 29, 1963

STANDARD, INC.

cc - Mr. J. J. [unclear]

Mr. J. J. [unclear]

1122 [unclear]

11-23-63 [unclear]

NOV 25 1963

NOV 25 1963

NOV 25 1963

Standard, Inc. [unclear]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80

28083

REG. NO.

|   |   |   |  |  |   |
|---|---|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>LOUISE ----- GIBBONS  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 15 80                                      |  | 2b. HOUR<br>12:05 AM  |
| 3. SEX<br>FEMALE  | 4. RACE<br>WHITE  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6 29 95   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>85 YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>GERMANY  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                           |  |   |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SOUTH BALTIMORE GENERAL HOS. |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE        | 12b. KIND OF BUSINESS OR INDUSTRY  |   |
| 13a. STATE<br>MD  |   |   | 13b. COUNTY<br>BALTIMORE   | 13c. CITY OR TOWN<br>BALTIMORE   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>LOUIS ----- HARTMANN  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>SOPHIE ----- ALBIG                  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>217-30-3237  | 17. INFORMANT<br>ADDRESS<br>DORSEY WEAR, SAME AS ABOVE  |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>4100 IMMEDIATE CAUSE (a) <u>Pulmonary edema + atelectasis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Chronic pulmonary congestion: Cardiac fibrosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Old + recent myocardial infarction</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Generalized arteriosclerosis</u> |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Seven   |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10-15</u> , 19 <u>80</u> , to <u>11-15</u> , 19 <u>80</u> , that (I) (we) lost<br>saw the deceased alive on <u>11-14</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |   |   |  |  |   |
| 22b. SIGNATURE<br><u>Susan Voss, MD</u>   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        | 22c. DATE SIGNED<br>11/15/80   |  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>SUSAN VOSS, MD   |   | 22e. ADDRESS<br>3001 S. HANOVER ST. Baltimore, Md. 21230  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  | 23b. DATE<br>Nov. 18, 1980  | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowridge Mem. Park   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Dorsey, Howard Co. Maryland            |  |   |
| 24. FUNERAL DIRECTOR<br>McCurly Funeral Home, 237 E. Patapsco Ave. Balto.   |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 19 1980  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                                     |  |   |



MEMORANDUM  
FOR THE DIRECTOR  
FROM: SAC, NEW YORK  
SUBJECT: [Illegible]



*[Handwritten signature]*

DATE: 10/1/60

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 0 8 4

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |  |   |  |   |  |   |  |
|--|--|--|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Columbus C. Gibbs   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 29, 1980               |   | 2b. HOUR<br>8:52a M  |   |  |   |  |   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Negro   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2 05 07   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>73 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>S.C.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Maryland General Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Lumber   |  |   |  |
| 13a. STATE<br>MD   |  |  |  |   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>ANANIAS  |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>CLAUDIA  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |  |  |   |  | 16b. SOCIAL SECURITY NO.<br>219-07-0574   |  | 17. INFORMANT<br>ADDRESS<br>F. VOLYN C. BAS 2800 BOCKEN DR.   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>3229 IMMEDIATE CAUSE (a) Acute Meningitis - Streptococcus Pneumoniae<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>Micronodular Cirrhosis  |  |  |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |   |  |   |  |
| 22a. I certify that (X) (this hospital) attended the deceased from November 25, 1980 to November 29, 1980, that (X) (we) lost<br>saw the deceased alive on November 29, 1980, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (X) (we) (did) not view the body after death. |  |  |  |   |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br>Dr. Joseph Gent  |  |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>11-29-80  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Joseph Gent, M.D.   |  |  |  |   |  | 22e. ADDRESS<br>c/o 827 Linden Ave. Balto. MD 21201   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  |  | 23b. DATE<br>12/3/80   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>BARKHUS                                  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO MD 21207 |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>V. Harris  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 2 1980   |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 0 8 5

REG. NO.

|  |  |  |   |   |   |   |  |  |  |
|--|--|--|---|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARGARET E. GIBSON</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 14 80</b>                |   | 2b. HOUR<br><b>9:30 P.M.</b>  |   |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>white</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>02 / 13 / 04</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b> YRS.   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. City</b> MD.                                  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Bon Secours Hospital</b> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOME MAKER</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a. STATE<br><b>md.</b>   |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>BALTO.</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>4517 Pennington Ave.</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George Kenner</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Matilda BOEHM</b> |   |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>218-74-1014</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Mr. Joseph Gibson same as 13 e</b>   |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Possible stroke</b><br><b>4279</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Cardiovascular collapse, possible</b><br>(c) <b>Arteriosclerosis</b>              |  |  |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |   |   |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>             |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9/26</b> , 19 <b>80</b> , to <b>10/14</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>10/14</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |   |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Helen A. Kennedy</b>  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   |   | 22c. DATE SIGNED<br><b>10/15/80</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Helen A. Kennedy</b>   |  |  |   | 22e. ADDRESS<br><b>Baltimore City</b>   |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>   |  | 23b. DATE<br><b>11/18/80</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem Pk</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glen Burnie A.A. Md.</b>                       |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>George J. Gonce 4001 Ritchie Hgwy.</b>  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 18 1980</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Helen A. Kennedy</b>   |  |  |  |

0% COLLOIDAL

*[Faint, illegible handwriting]*

CCU17 2 BALTIMORE, MARYLAND 21201  
GILLION MARIAN  
11 207 30

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed by a physician who has attended the deceased within 72 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 8 0 2 8 0 8 6   |  |
|--|--|---|--|---|--|
| 1 - FOR<br>STATE<br>REGISTRAR  |  |   |  | CERTIFICATE OF DEATH  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   |  | 2a. DATE OF DEATH   |  |
| FIRST MARIAN MIDDLE GILLION LAST GILLION   |  |   |  | MONTH NOVEMBER DAY 15 YEAR 1980   |  |
| 3. SEX<br>FEMALE   |  |   |  | 2b. HOUR<br>07:47AM   |  |
| 4. RACE<br>NEGRO   |  | 5. DATE OF BIRTH<br>MONTH NOV. DAY 7 YEAR 1930  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>50 YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>NORTH CAROLINA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>US of A   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.  |  |
| 13a. STATE<br>MARYLAND   |  | 13b. COUNTY<br>BALTIMORE  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>PROCESSER   |  |
| 14. FATHER'S NAME<br>FIRST CALVIN MIDDLE HARGROVE LAST HARGROVE  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST ESTELLA MIDDLE SMITH LAST SMITH   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>LAUNDRY  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>242 38 8661   |  | 17. INFORMANT<br>ADDRESS<br>REV. ROBERT GILLION 503 N. CASTLE STREET  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardio pulmonary arrest</u><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>probable inferior &amp; anterior myocardial infarct</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <u>coronary artery disease</u> |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>hypertension</u>  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11-15-</u> 19 <u>80</u> , to <u>11-15</u> 19 <u>80</u> , that (I) (we) lost<br>saw the deceased alive on <u>11-15</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |
| 22b. SIGNATURE<br><u>William T. Kelley</u>   |  |   |  | 22c. DATE SIGNED<br><u>11-15-80</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>William T. Kelley</u>  |  |   |  | 22e. ADDRESS<br><u>Johns Hopkins Hospital.</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  | 23b. DATE<br>11/20/80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>RHODES CEMETERY   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>LEWIS T. GWYNN   |  | ADDRESS<br>4517 PARK HEIGHTS AVENUE   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>DUDLEY (WAYNE) N. C.  |  |
| 25a. DATE REC'D. BY REGISTRAR<br>NOV 17 1980   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><u>L. H. H. H.</u>  |  |

15

SEP 7 1935

७२

475

2000 年 4 月 15 日 星期五

 $\Sigma$ 

YH, 2045

X

## References

1125

345 38 1001

• 0 • ( = 1746 )

CL / CS / 1.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 0 8 7

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |   |  |   |                     |   |  |  |  |                              |  |
|--|--|---|--|---|---------------------|---|--|--|--|------------------------------|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Rose XXX Gimbel   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>11 / 22 / 80 |   | 2b. HOUR<br>7:35 PM |   |  |  |  |                              |  |
| 3 SEX<br>Female  |  | 4 RACE<br>White   |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>7 7 16  |                     | 6 AGE (IN YEARS LAST BIRTHDAY)<br>64 YRS  |  | 7 UNDER 1 YEAR<br>MONTHS DAYS            |  | 7 UNDER 24 HRS<br>HOURS MIN. |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7c. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                     | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                             |  |  |  |                              |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH A FACILITY, GIVE STREET ADDRESS)<br>BALTIMORE CITY HOSPITAL CENTER |  |   |                     | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FORMER OR WORKING LIFE)<br>SECRETARY           |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>JNF |  |                              |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE MARYLAND 13b. COUNTY MONT. 13c. CITY OR TOWN SILVER SPRING 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |   |                     | 13e. STREET ADDRESS<br>8103 EASTERN AVE. #20910                                       |  |  |  |                              |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>ISAAC FAGAN  |  |   |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>SARAH CHENKIN  |                     |   |  |  |  |                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO  |  |   |  | 16b. SOCIAL SECURITY NO<br>217-16-7353  |                     | 17 INFORMANT SAMUEL GIMBEL ADDRESS 8103 EASTERN AVE. APT. 503 SILVER SPRING, MD 20910 |  |  |  |                              |  |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

1991  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Respiratory Failure

metastatic Adenocarcinoma

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

MEDICAL CERTIFICATION

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>H. Gerad, M.D.  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>11/22/80   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Henry Gerad, M.D.  |  |  |  | 22e. ADDRESS<br>UNIVERSITY HOSP. - BALTO., MD  |  |  |  |

|  |  |                       |  |   |  |  |  |
|--|--|-----------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  | 23b. DATE<br>11/24/80 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>AGUDAS BNAI JACOB LODGE |  | 23d. LOCATION<br>CITY OR TOWN COUNTY<br>ROSEDALE BALTO. MD |  |
| 24 FUNERAL DIRECTOR<br>NAME SOL LEVINSON & BROS., INC.<br>ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215 |  |                       |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 25 1980                  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]                  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



24

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80

28088

REG. NO.

|   |  |   |   |   |  |  |   |  |   |  |
|---|--|---|---|---|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>J. WALTER GISRIEL, JR.</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 13 80</b>                      |   |  | 2b. HOUR<br><b>254 P M</b>   |   |  |   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>April 15, 1905</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b>   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS.</b>  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                    |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Executive</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Fuel Co.</b>   |   |  |
| 13a. STATE<br><b>Maryland</b>   |  |   | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>114 Castlewood Road</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>J. Walter Gisriel</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Sarah Grace Kidwell</b> |   |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  |   | 16b. SOCIAL SECURITY NO.<br><b>217 18 8007</b>                              |   | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Dorothy McCoy Gisriel (Same)</b>           |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Anterior Myocardial Infarction</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>IN EVOLUTION</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>(b) <b>ASCVD</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>7 HRS.</b> |  |   |   |   |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Congestive Heart Failure, Atrial Fibrillation</b>   |  |   |   |   |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                            |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>           |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)      |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>11-13</b> , 19 <b>80</b> , to <b>11-13</b> , 19 <b>80</b> , that (we) lost saw the deceased alive on <b>11-13</b> , 19 <b>80</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above (we) (and) did not view the body after death.   |  |   |   |   |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Alvin R. Sills, MD</b>   |  |   |   |   | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>11/13/80</b>   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>STACK, A MARIA MD</b>   |  |   |   |   | 22e. ADDRESS<br><b>UNION MEMORIAL HOSPITAL</b>                                 |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>  |  |   | 23b. DATE<br><b>11/15/80</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount</b>                       |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto., Md.</b>                                |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Henry W. Jenkins &amp; Sons Co.</b><br>ADDRESS<br><b>4905 York Road Balto., Md. 21212</b>  |  |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 17 1980</b>                            |  | 25b. REGISTRAR'S SIGNATURE<br><b>Barney</b>   |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

11-12

WFOU

WALTER

77. 77.

57

531, at 530.

stina

11

WINDMILL CREEK

1-2 U

### Conclusion

UNION NATIONAL

ESCHERICH,

Executive  
Fidelity Investments

11. *Salmonella*

1907

New Jersey 07033

Isirid

Walden

• L

(c) (1) 2007 Mrs. Dorothy McCoy (deceased)

сд

DATE: 10/10/1964

2000, 2001, 2002

DRAFT

\_\_\_\_\_

Henry W. Jenkins & Sons Co.

4505 York Road, Suite 100, York, PA 17403

082137 VGTa





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO. 8028089  |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>NORMAN P. GITOMER</b>   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11/20/80</b>  |  |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 11 20</b>   |  | 2b. HOUR<br><b>2:21 AM</b>   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Baltimore</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore City</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sinai Hospital of Baltimore</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Salesman</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>United Insur.</b>  |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>BALTO.</b>  |  | 13c. CITY OR TOWN<br><b>Balt.</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Samuel Gitomer</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rebecca Hett</b>  |  | 13e. STREET ADDRESS<br><b>5623 GROVELAND AVE. #21215</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>yes</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>213-16-0593</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Rivalee J. Gitomer 5623 GROVELAND AVE. (SAME) #21215</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br><b>1623</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>MASSIVE Hemoptysis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <b>Long Abscess Erosion into Large Pulm. Vessel</b> |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Hx Squamous Cell Cancer Right Upper Lung</b>   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/18</b> , 19 <b>80</b> to <b>11/20</b> , 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>11/20</b> , 19 <b>80</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Jeffrey H. Chircus MD</b>   |  |   |  | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>11/20/80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Jeffrey H. Chircus M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>Sinai Hospital of Baltimore</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>11/21/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ARLINGTON (CHIZUK AMUNO) BALTIMORE</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>SOL LEVINSON &amp; BROS., INC.</b><br><b>6010 REISTERSTOWN RD. BALTO. MD 21215</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 25 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |

*Handwritten signature*

NOV 2 1960

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 0 9 0

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>ANGELO C GIUNTA  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11-8-80 |   |  | 2b. HOUR<br>18 <sup>07</sup> M   |  |
| 3. SEX<br>M  |  | 4. RACE<br>Cauc  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 24 17  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>63<br>IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN.                         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>PENN.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore City  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BCRP, University Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Supervisor   |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br>Construction  |  | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>PENN                     |  | 13b. COUNTY<br>Luzerne  |  | 13c. CITY OR TOWN<br>FORTY FORT  |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br>1511 WYOMING AVE  |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>SAM GIUNTA  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>THERESA COSTANZO  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>W.W. II 19807 0118  |  | 17. INFORMANT<br>ADDRESS<br>Kathryn Giunta Forty Fort, Pa.  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Chronic myelogenous leukemia, blastic phase</u><br>2051<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>CANDIDIASIS</u> |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8 Nov</u> , 19 <u>80</u> , to <u>8 Nov</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>8 Nov</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Elizabeth Poplin</u>  |  | DEGREE<br>MD   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br>8 Nov 80   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Elizabeth Poplin MD   |  | 22e. ADDRESS<br>BCRP, 22 S. Greene St<br>Baltimore Md.   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>Nov. 11, '80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Denison Cemetery  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Swoyersville, Pa.  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>William E. Johnson 8521 Loch Raven Blvd.   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 10 1980  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Barbara M. Brady</u>  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

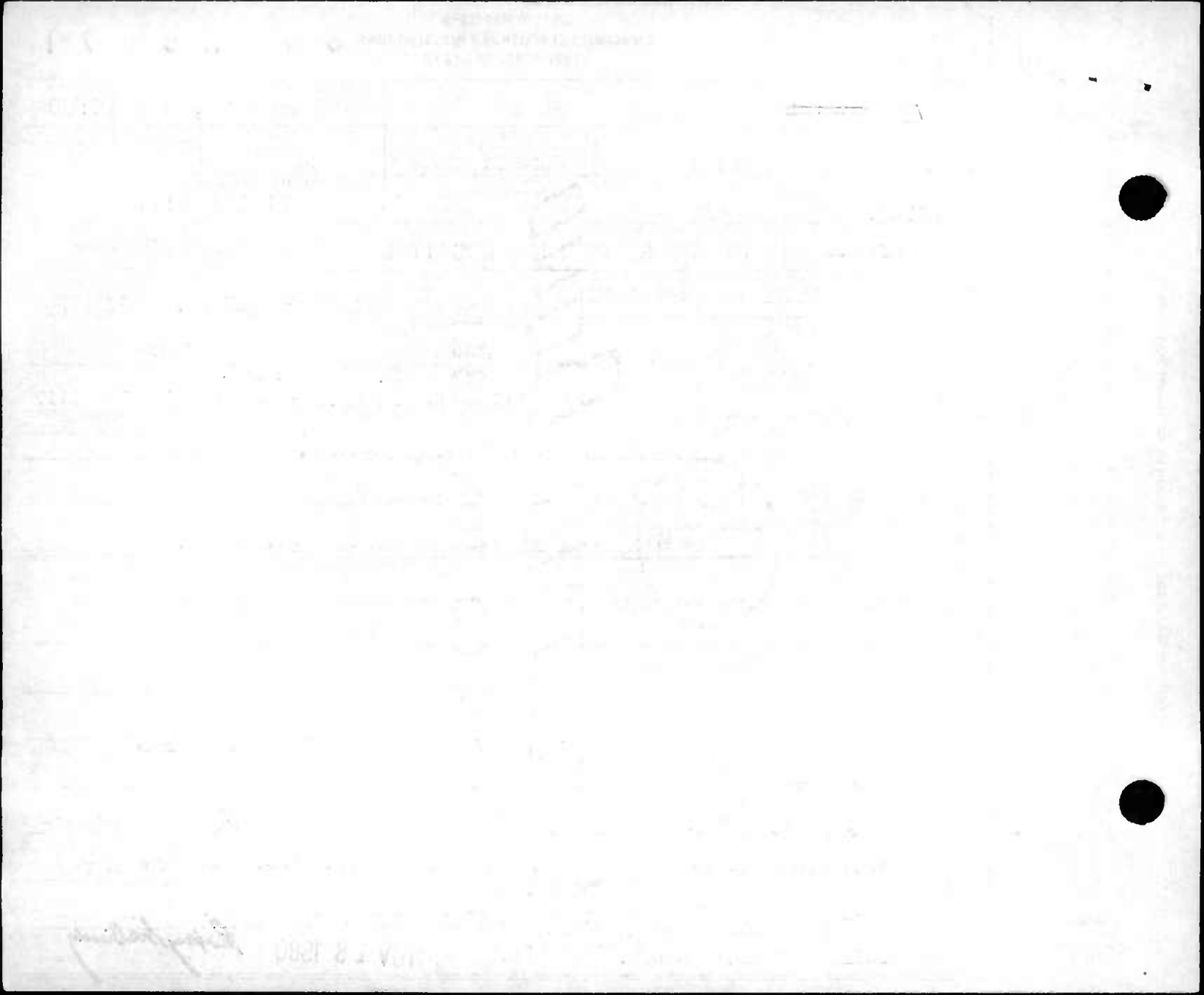
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 0 9 1

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|  |  |  |   |   |  |   |  |
|--|--|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>E. ARLINE ARLINE GLASS</b>   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>NOVEMBER 13, 1980</b>                      |   | 2b. HOUR<br><b>1:00A</b>                               |   |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>JUNE 21, 1924</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS<br><b>56 YRS.</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>      |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |   | 12a. USUAL OCCUPATION (TYPE OF WORK OR BUSINESS) (LIFE)<br><b>HOUSEWIFE</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE 13c. COUNTY<br><b>MARYLAND BALTIMORE OWINGS MILLS</b>   |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>11106 VERDANT RD. #21117</b> |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>UNKNOWN ANDERSON</b>   |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>ETHEL UNKNOWN</b>                |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>219-10-1517</b>   |   | 17. INFORMANT<br><b>MR. MORRIS GLASS</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b><br>1830<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Cardiovascular Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Widely metastatic ovarian carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |  |   |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12 NOV 1980</b> to <b>13 NOV 1980</b> , that (I) (we) lost saw the deceased alive on <b>13 NOV 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |   |  |   |  |
| 22b. SIGNATURE<br><b>Rafael Hacisk</b>   |  | DEGREE<br><b>MD</b>  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>13 NOV 80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RAFAEL HACISK MD</b>   |  | 22e. ADDRESS<br><b>JOHNS HOPKINS HOSPITAL OB GYN</b>   |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>11/14/80</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BETH EL MEMORIAL PARK</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>RANDALLSTOWN BALTO MD</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>SOL LEVINSON &amp; BROS., INC.</b><br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>   |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 18 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |   |  |  |  | 8 0 2 8 0 9 2  |  |                               |   |  |  |   |  |
|--|--|---|--|--|--|---|--|--|--|--|--|-------------------------------|---|--|--|---|--|
| 1 - FOR STATE REGISTRAR  |  |   |  |  | REG. NO.   |   |  |  |  |  |  |                               |   |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>HARRY A. GOLDBERG  |  |   |  |  | 2r. DATE OF DEATH MONTH DAY YEAR<br>NOVEMBER 9, 1980   |   |  |  |  | 2b. HOUR A M<br>11:45 A  |  |                               |   |  |  |   |  |
| 3 SEX<br>MALE  |  | 4 RACE<br>WHITE   |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>JUNE 22, 1904                        |  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>76 YRS |  |  | 7 UNDER 1 YEAR<br>MONTHS DAYS  |  | 7 UNDER 24 HRS<br>HOURS MIN   |   |  |  |   |  |
| 8 BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>PENNSYLVANIA  |  | 9b CITIZEN OF WHAT COUNTRY?<br>USA  |  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD                             |  |  |  |                               |   |  |  |   |  |
| 10 CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>3900 N. CHARLES ST., APT. 1404 |  |  |  |   |  |  |  | 12r. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>PROPRIETOR  |  |                               | 12b. KIND OF BUSINESS OR INDUSTRY<br>LUMBER |  |  |   |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE MARYLAND  |  |   |  |  |  |   |  |  |  | 13b COUNTY   |  | 13c CITY OR TOWN<br>BALTIMORE |   | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13r. STREET ADDRESS<br>3900 N. CHARLES ST. #21218 |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>UNKNOWN GOLDBERG   |  |   |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>HANNAH MILLER  |   |  |  |  |  |  |                               |   |  |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO   |  |   |  |  | 16b SOCIAL SECURITY NO.<br>138-03-6079A  |   |  | 17 INFORMANT ADDRESS<br>MRS. SAYDE GOLDBERG<br>3900 N. CHARLES ST., APT. 1404 #21218 |  |  |  |                               |   |  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) VENTRICULAR TACHYCARDIA<br>4271<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>OTHER SCENARIOS |  |   |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>SUDDEN   |  |                               |   |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |   |  |  |  |  |  |                               |   |  |  |   |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                               |   |  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |                               |   |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |   |  | 21r. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21i. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |                               |   |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from June 1961, to Sept 2 1980, that (I) (we) last saw the deceased alive on Sept 2 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |  |  |  |   |  |  |  |  |  |                               |   |  |  |   |  |
| 22b. SIGNATURE<br>Dr. Samuel Whitehouse M.D.   |  |   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |  | 22c. DATE SIGNED   |  |                               |   |  |  |   |  |
| 22r. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. SAMUEL WHITEHOUSE   |  |   |  |  |  | 22r. ADDRESS<br>3900 N. CHARLES ST. #21218  |  |  |  |  |  |                               |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  |   |  | 23b. DATE<br>11/10/80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>BNAT ISRAEL   |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MARYLAND   |  |                               |   |  |  |   |  |
| 24 FUNERAL DIRECTOR NAME<br>SOL LEVINSON & BROS., INC.<br>6010 REISTERSTOWN RD. BALTO., MD 21215   |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 12 1980  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br>P. H. H. H.  |  |                               |   |  |  |   |  |

100-100000-100000

100-100000-100000

100-100000-100000



FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 0 9 3

REG. NO.

|  |                         |   |  |   |  |
|--|-------------------------|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Albert Goodman</i>  |                         | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>11-22-80</i>                                     |  | 2b. HOUR <i>9:28 PM</i>   |  |
| 3. SEX<br><i>MALE</i>  | 4. RACE<br><i>White</i> | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>2-1-05</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>75</i> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Baltimore City</i>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <i>XXXX</i> |  |
| 9a. CITY OR TOWN OF DEATH<br><i>Baltimore</i>  |                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><i>Mitchell Nursing Home</i> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>ARTIST</i>  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>  |                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><i>Mitchell Nursing Home</i> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>COMMERCIAL ART</i>  |  |
| 13a. STATE<br><i>MD</i>  |                         | 13b. COUNTY<br><i>BALTIMORE</i>   |  | 13c. CITY OR TOWN<br><i>BALTIMORE</i>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>UNKNOWN GOODMAN</i>  |                         | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>UNKNOWN</i>                            |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><i>NO</i>   |                         | 16b. SOCIAL SECURITY NO.<br><i>220-46-3755</i>  |  | 17. INFORMANT<br><i>HEBREW BURIAL &amp; SOC. SER. SOC.</i>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Massive Cerebral Vascular Accident</i><br>4029<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Hypertensive cardio-vascular disease</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>5 yr</i> |                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>7 hour</i><br><i>Years</i>           |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |                         |   |  |   |  |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                         | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>                          |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                     |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Nov. 20, 19 68</i> to <i>Nov. 22, 19 80</i> , that (I) (we) lost saw the deceased alive on <i>Nov. 21, 19 80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) (did not) view the body after death.   |                         |   |  |   |  |
| 22b. SIGNATURE<br><i>Dr. M. Zimmerman MD</i>   |                         | DEGREE<br><i>MD</i>   |  | 22c. DATE SIGNED<br><i>11/22/80</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Dr. M. Zimmerman M.D.</i>  |                         | 22e. ADDRESS<br><i>3202 Harford Rd. Baltimore, Md.</i>                                  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>BURIAL</i>   |                         | 23b. DATE<br><i>11/25/80</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>BALTIMORE HEBREW</i>   |  |
| 23d. LOCATION CITY OR TOWN<br><i>BALTIMORE</i>   |                         | COUNTY<br><i>BALTIMORE</i>  |  | STATE<br><i>MARYLAND</i>  |  |
| 24. FUNERAL DIRECTOR NAME<br><i>SOL LEVINSON &amp; BROS., INC.</i>   |                         | 25a. DATE REC'D. BY REGISTRAR<br><i>DEC 3 1980</i>                                      |  | 25b. REGISTRAR'S SIGNATURE<br><i>H. H. Brady</i>  |  |
| 6010 REISTERSTOWN RD. BALTO., MD 21215   |                         |   |  |   |  |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |   |   |  |  |  | 8028094 |
|---|--|---|--|---|---|---|--|--|--|---------|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO.  |  |   |   |   |  |  |  |         |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Elmer Milton Goodrich</b>   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11/3/80</b>                     |   |  | 2b. HOUR<br><b>10:50P</b>  |  |         |
| 3. SEX<br><b>M</b>  |  | 4. RACE<br><b>W</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7/26/11</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |         |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |  |  |         |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST AGNES HOSPITAL</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>REFRIGERATION</b>        |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>BETH STEEL</b>   |  |         |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   |   |   |  |  |  |         |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>511 SOUTH LONGWOOD ST.</b>   |  |         |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>MARSHALL GOODRICH</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARY ANN LEVERING</b> |   |  |  |  |         |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>---</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>DOROTHY GOODRICH 511 SOUTH LONGWOOD ST.</b>  |   |   |  |  |  |         |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest &amp; Respiratory failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Adenocarcinoma of colon</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Liver Metastasis</u><br>Approximate Interval Between Onset and Death<br><u>1 1/2 years</u><br><u>2 years</u> |  |   |  |   |   |   |  |  |  |         |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |   |   |  |  |  |         |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |         |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |  |  |  |         |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |  |  |         |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 3, 1980</u> to <u>Nov 3, 1980</u> , that (I) (we) last saw the deceased alive on <u>Nov 3, 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |   |   |  |  |  |         |
| 22b. SIGNATURE<br><u>T.P. Reddy</u>   |  |   |  | DEGREE <u>MD</u><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   |  | 22c. DATE SIGNED<br><u>Nov 3, 1980</u>   |  |         |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>DR-T.P. REDDY</u>   |  |   |  | 22e. ADDRESS<br><b>900 CATON AVE BALTIMORE MD 21229</b>   |   |   |  |  |  |         |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>11/7/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CRESTLAWN MEM PARK</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>MARRIOTTSTVILLE HOWARD MD.</b>                 |  |  |  |         |
| 24. FUNERAL DIRECTOR<br><b>HUBBARD FUNERAL HOME 4107 WILKINS AVE.</b>   |  |   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 6 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Robt McBrady</u>  |  |         |

ALLIANCE CITY

ST. ALBANS HOSPITAL

ST. ALBANS HOSPITAL

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

2 8 0 9 5

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |  |  |   |   |   |  |  |
|---|--|--|--|--|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>VERONICA R. GOONAN   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 28 80                        |  |  | 2b. HOUR<br>9:55 AM   |   |   |  |  |
| 3 SEX<br>FEMALE   |  | 4 RACE<br>11 White   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>7 24 94   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>86 YR   |   |   |  |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>BALT. MD.  |  | 7c. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALT. CITY MD.   |   |   |  |  |
| 10 CITY OR TOWN OF DEATH<br>BALT.   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>CATON MANOR NSRC CENTER |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SEAMRESS                    |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |  |  |   |   |   |  |  |
| 13a. STATE<br>MD  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>BALT.   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br>1906 Chiquet Rd. RP.   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>TIMOTHY - GOONAN  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ELLA - KANE           |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                            |   |   | 16b. SOCIAL SECURITY NO.<br>216-20-9338  |  |
| 17 INFORMANT<br>Mr. Gilbert Stricker  |  |  | 18 ADDRESS<br>1906 Edgewood Rd. 21234                                  |  |  | 19  |   |   | 20   |  |
| 11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u><br>4140<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Arteriosclerotic Heart Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |  |  |  |  |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>Permanent Paralysis</u>   |  |  |  |  |  |   |   |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>E. 30th St. 11 28 80 7                     |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10:29</u> 19 <u>80</u> to <u>11:28</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>10:29</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |   |   |  |  |
| 22b. SIGNATURE<br><u>[Signature]</u> DEGREE <u>MD</u>   |  |  |  |  |  | 22c. DATE SIGNED<br>11-29-80  |   |   | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>5400 OLD COURT RD RANDALLSTOWN MD 21133 |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  |  | 23b. DATE<br>Dec. 4, 1980  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>New Cathedral Cem. BALT. |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALT. MD. |   | 23e. DEC'D. BY REGISTRAR   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>G. TRUMAN Schaub 65151 Balto. National Pike   |  |  |  |  |  | 25a. DEC'D. BY REGISTRAR  |   |   |  |  |



*[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page.]*

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

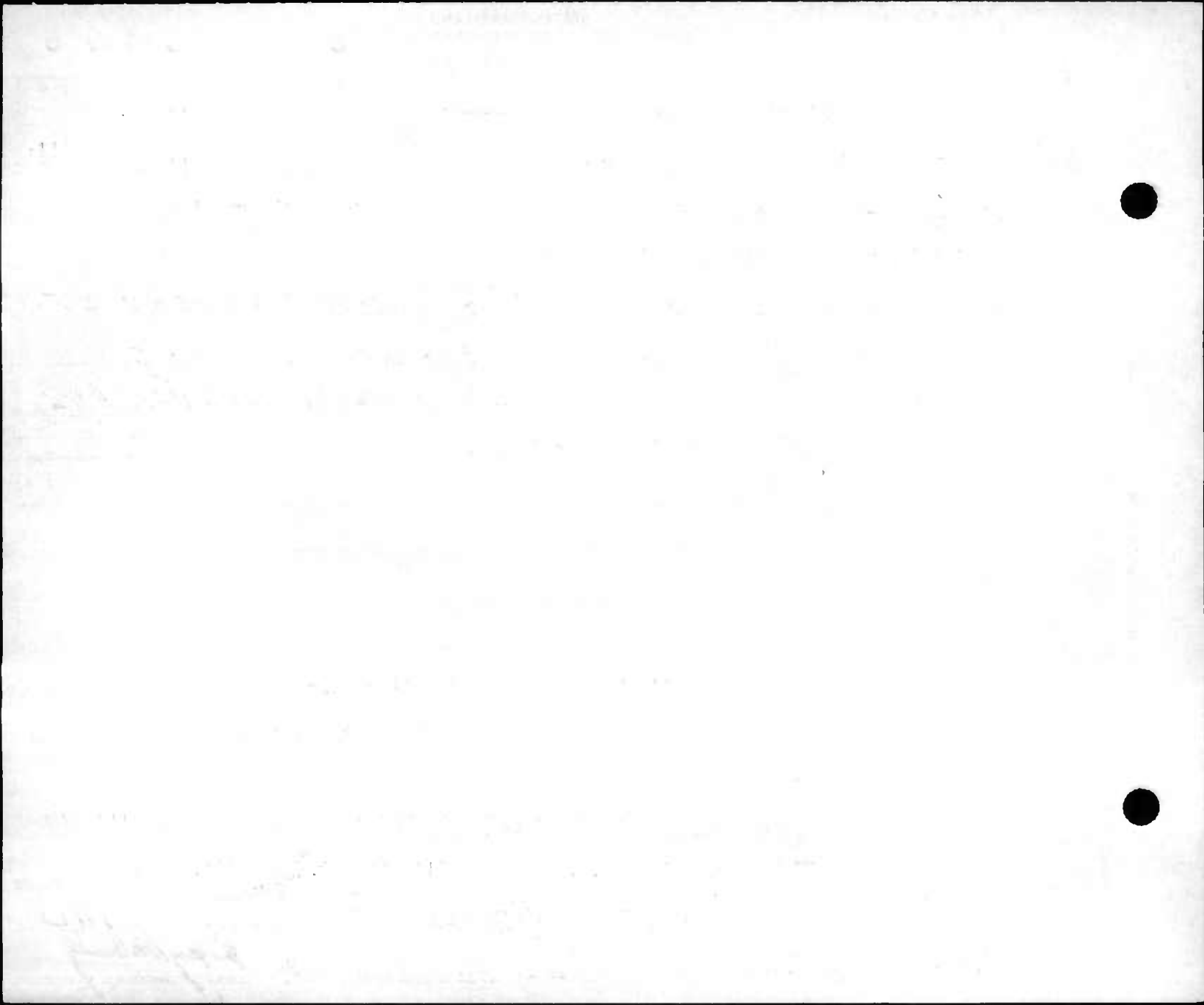
DHMH - 17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |         |   |                                 |
|--|---------|---|---------------------------------|
| 1- FOR STATE REGISTRAR   |         | 8 0 2 8 0 9 6   |                                 |
| 1. DECEASED NAME (TYPE OR PRINT)   |         | 2a. DATE KNOWN OF DEATH   |                                 |
| FIRST MIDDLE LAST Robert M. Gorecki  |         | MONTH DAY YEAR 11 23 19 80  |                                 |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH (MONTH DAY YEAR)   | 6. AGE (IN YEARS LAST BIRTHDAY) |
| Male   | White   | JAN. 15 1936  | 44 YRS.                         |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?  |                                 |
| MARYLAND   |         | U.S.A.  |                                 |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                 |
| Baltimore  |         | 325 S. Madiera Street   |                                 |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |         | 12b. KIND OF BUSINESS OR INDUSTRY   |                                 |
|  |         |   |                                 |
| 13a. STATE   |         | 13b. COUNTY   |                                 |
| MARYLAND   |         | BALTIMORE   |                                 |
| 13c. CITY OR TOWN  |         | 13d. INSIDE CITY LIMITS?  |                                 |
| BALTIMORE  |         | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                     |                                 |
| 13e. STREET ADDRESS  |         | 15. MOTHER'S MAIDEN NAME  |                                 |
| 325 S. MADIERA ST.   |         | ELEANOR BANACK  |                                 |
| 14. FATHER'S NAME (FIRST MIDDLE LAST)  |         | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)                                      |                                 |
| JOSEPH GORECKI   |         | NO  |                                 |
| 16b. SOCIAL SECURITY NO.   |         | 17. INFORMANT (NAME AND ADDRESS)  |                                 |
|  |         | EDW. GORECKI 2633 FAIR AVE  |                                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY:   |         |   |                                 |
| IMMEDIATE CAUSE (a) Cranio cerebral trauma   |         |   |                                 |
| DUE TO, OR AS A CONSEQUENCE OF   |         |   |                                 |
| (b)  |         |   |                                 |
| DUE TO, OR AS A CONSEQUENCE OF   |         |   |                                 |
| (c)  |         |   |                                 |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |         |   |                                 |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |                                 |
|  |         |   |                                 |
| 20. AUTOPSY?   |         | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                     |                                 |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         | 21b. TIME OF INJURY (HOUR A.M. MONTH DAY YEAR) est. 11 23 19 80   |                                 |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |         | subject fell at home  |                                 |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>   |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |                                 |
| home   |         | 21f. LOCATION (STREET CITY OR TOWN COUNTY STATE)  |                                 |
| 325 S. Madiera St. Balto.  |         | MD  |                                 |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |   |                                 |
| ACTUAL SIGNATURE   |         | TITLE (SPECIFY)   |                                 |
| Thomas D. Smith, M.D.  |         | Deputy Chief  |                                 |
| EXAMINER'S NAME (TYPE OR PRINT)  |         | DATE SIGNED   |                                 |
| Thomas D. Smith, M.D.  |         | 11/25/80  |                                 |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         | 23b. DATE   |                                 |
| BURIAL   |         | 11/1/1980   |                                 |
| 23c. NAME OF CEMETERY OR CREMATORY   |         | 23d. LOCATION (CITY OR TOWN COUNTY STATE)   |                                 |
| ST. STANISLAUS   |         | BALTIMORE MD  |                                 |
| 24. FUNERAL DIRECTOR (NAME AND ADDRESS)  |         | 25a. DATE REC'D. BY REGISTRAR   |                                 |
| RAYMOND L. KACZOROWSKI 2525 FLEET ST.  |         | DEC. 2 1980   |                                 |
| 25b. REGISTRAR'S SIGNATURE   |         |   |                                 |
| R. Kaczorowski   |         |   |                                 |

BP





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

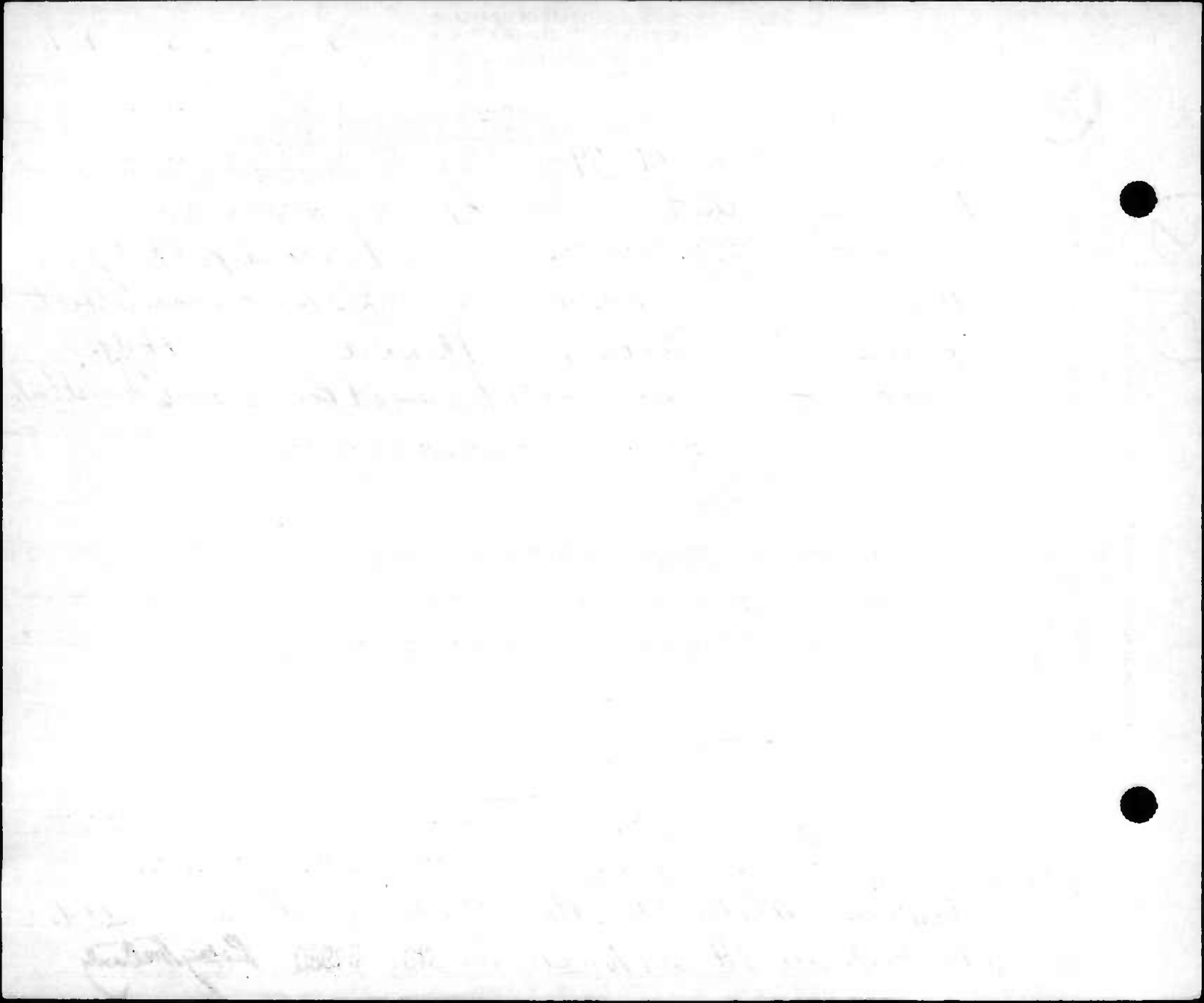
2001  
DHMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |         |   |                   |
|--|---------|---|-------------------|
| 1- FOR STATE REGISTRAR   |         | 8 0 2 8 0 9 7   |                   |
| 1. DECEASED NAME (TYPE OR PRINT)   |         | 2a. DATE KNOWN OF DEATH   |                   |
| Howard Gorham  |         | DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 11 2 19 80 |                   |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH  | 6. AGE (IN YEARS) |
| Male   | Black   | 3 13 01   | 19 YRS.           |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?  |                   |
| New Jersey   |         | USA   |                   |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |         | 9. BALTIMORE CITY OR COUNTY OF DEATH  |                   |
| Baltimore City, MD.  |         |   |                   |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION                          |                   |
| Baltimore  |         | 213 N. Monroe St.   |                   |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |         | 12b. KIND OF BUSINESS OR INDUSTRY   |                   |
| Labor Sup. (Ret.)  |         |   |                   |
| 13a. STATE   |         | 13b. COUNTY   |                   |
| MD   |         | BALTO.  |                   |
| 13c. CITY OR TOWN  |         | 13d. INSIDE CITY LIMITS?  |                   |
| BALTO.   |         | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>               |                   |
| 13e. STREET ADDRESS  |         | 13f. STREET ADDRESS   |                   |
| 213 N. Monroe Street   |         | 213 N. Monroe Street  |                   |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME  |                   |
| Primus Gorham  |         | Minnie Hodge  |                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |         | 16b. SOCIAL SECURITY NO.  |                   |
| UNK  |         | 212-09-6231   |                   |
| 17. INFORMANT  |         | ADDRESS   |                   |
| Lenwood Bowers   |         | 3636 Forrest Garden   |                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |   |                   |
| PART I DEATH WAS CAUSED BY:  |         |   |                   |
| IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u>   |         |   |                   |
| DUE TO, OR AS A CONSEQUENCE OF   |         |   |                   |
| (b) _____  |         |   |                   |
| DUE TO, OR AS A CONSEQUENCE OF   |         |   |                   |
| (c) _____  |         |   |                   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |         |   |                   |
| 19a. DATE OF OPERATION   |         |   |                   |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |         |   |                   |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |         |   |                   |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                              |                   |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |         |   |                   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                       |                   |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |         |   |                   |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |   |                   |
| ACTUAL SIGNATURE   |         | DATE (SPECIFY)  |                   |
| Thomas D. Smith  |         | M.D. Deputy Chief   |                   |
| EXAMINER'S NAME (TYPE OR PRINT)  |         | ADDRESS   |                   |
| Thomas D. Smith, M.D.  |         | 111 Penn St. Balto., Md.  |                   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         | 23b. DATE   |                   |
| Burial   |         | 11/6/80   |                   |
| 23c. NAME OF CEMETERY OR CREMATORY   |         | 23d. LOCATION CITY OR TOWN COUNTY STATE   |                   |
| Woodlawn Cemetery  |         | Woodlawn Baltimore Md.  |                   |
| 24. FUNERAL DIRECTOR NAME  |         | 25a. DATE REC'D. BY REGISTRAR   |                   |
| Clas. H. Powell F/H  |         | NOV 5 1980  |                   |
| ADDRESS  |         | 25b. REGISTRAR'S SIGNATURE  |                   |
| 319 N. Schroeder   |         | L. J. H. H. H.  |                   |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |   |  |  | 8 0 2 8 0 9 8                      |  |
|--|--|--|--|---|--|---|---|--|--|------------------------------------|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO.   |  |   |  |   |   |  |  |                                    |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>John H Gorsky</b>  |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 2, 1980</b>                 |   |   | 2b. HOUR<br>M  |  |                                    |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 9, 1918</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b>  |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Germany</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |   |  |  |                                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3002 Orlando Ave</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Machinist</b>            |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                                    |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>3002 Orlando Ave</b>   |  |                                    |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Jo Hann Gorsky</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Marie ?</b>   |  |   |   |  |  |                                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>215-30-9845</b>  |  | 17. INFORMANT<br><b>Mrs Edeltraut Gorsky</b>  |  |   | ADDRESS<br><b>Same</b>  |  |  |                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrhythmia?</b><br>2500<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <b>Possible Acute MI</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <b>Diabetic Mellitus</b> |  |  |  |   |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Minute</b><br><b>Minute</b><br><b>Years</b>                             |                                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a   |  |  |  |   |  |   |   |  |  |                                    |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                    |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |   |  |  |                                    |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |   |  |  |                                    |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>Oct 24</b> , 19 <b>80</b> , to <b>Oct 24</b> , 19 <b>80</b> , that (1) (we) last saw the deceased alive on <b>Oct 24</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |   |  |  |                                    |  |
| 22b. SIGNATURE<br><b>Lawrence Mills</b> M.D.   |  |  |  |   |  | DEGREE<br><b>M.D.</b>   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11/3/80</b> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Lawrence Mills M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>5601 Loch Raven Blvd Baltimore, Maryland</b>   |  |   |   |  |  |                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>11/5/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Garden Of Faith</b>  |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>  |  |  |                                    |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J Ruck Inc. Baltimore, Maryland</b>   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 5 1980</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Richard M. Brady</b>  |  |                                    |  |

BALTIMORE, MARYLAND

UNITED STATES OF AMERICA  
DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535



0801 3 VCV

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

2 8 0 9 9

REG. NO.

|  |  |   |  |   |                           |   |  |  |  |
|--|--|---|--|---|---------------------------|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>JAMES L GORSUCH</b>    |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>11-14-80</b>              |   | 2b. HOUR<br><b>1135AM</b> |   |  |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>CAUCASIAN</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>04-27-1897</b>  |                           | 6. AGE (IN YEARS LAST BIRTHDAY) YRS<br><b>83</b>  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                           | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b>                                   |  | MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE CITY</b>                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GOOD SAMARITAN HOSPITAL</b> |  |   |                           | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>STREET CAR CONDUCTOR</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY                        |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>BALT. CITY</b>  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |                           | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>2620 E. FAIRMOUNT AVE.</b>     |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Milton Gorsuch</b>                       |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Annie Smith</b> |   |                           |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b> |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW I</b>  |  | 17. INFORMANT<br><b>James M. Gorsuch</b>  |                           | ADDRESS<br><b>4709 Homesdale Ave.</b>   |  |  |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) **PNEUMONIA**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**ONE WEEK**

**4960**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(b) **CHRONIC OBSTRUCTIVE PULMONARY DISEASE****15 YEARS**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |
| 22a. I certify that (i) (this hospital) attended the deceased from <b>NOVEMBER 3</b> , 19 <b>80</b> , to <b>NOVEMBER 14</b> , 19 <b>80</b> , that (ii) (we) lost<br>saw the deceased alive on <b>NOVEMBER 14</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (ii) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Andrew P Harris</b>  |  |  |  | DEGREE<br><b>M.D.</b>  |  | 22c. DATE SIGNED<br><b>11/14/80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ANDREW P HARRIS, M.D.</b>   |  |  |  | 22e. ADDRESS<br><b>THE GOOD SAMARITAN HOSPITAL, BALTIMORE</b>                        |  |  |  |

|   |  |                              |  |  |  |   |  |
|---|--|------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                               |  | 23b. DATE<br><b>11/17/80</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sacred Heart Cem.</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>B. Dabrowski &amp; Son 2818 E. Baltimore St.</b> |  |                              |  | 25. DATE REC'D. BY REGISTRAR<br><b>NOV 17 1980</b>             |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 1 0 0

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|  |  |   |   |   |  |
|--|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>LAURA J GOSNELL  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11/26/80   |   | 2b. HOUR<br>12:20 PM   |
| 3. SEX<br>FEMALE   | 4. RACE<br>WHITE   | 5. DATE OF BIRTH<br>MAY 3, 1947   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>33   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>NEW YORK  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE                   | 12b. KIND OF BUSINESS OR INDUSTRY<br>HOME   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |   |   |  |
| 13a. STATE<br>MARYLAND   | 13b. COUNTY  | 13c. CITY OR TOWN<br>BALTIMORE  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>3501 ST. PAUL ST. ( 21218)                                     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>GEORGE FRIEDWALD   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>LENORE STEAL   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>264-78-1867   |   | 17. INFORMANT ADDRESS<br>RIVERSIDE MEMORIAL CHAPEL 180 W. 76th St. N.Y.C., N.Y. 10023 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>G.I. Bleeding - Massive</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Chronic Active Hepatitis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>11 months</u>  |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>12 hrs</u>  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)        |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                     |  |
| 22a. I certify that (I) this hospital attended the deceased from <u>11/26</u> 19 <u>80</u> to <u>11/26</u> 19 <u>80</u> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <u>11/26</u> 19 <u>80</u> , and that in my <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (If we) <input type="checkbox"/> (did not) view the body after death. |  |   |   |   |  |
| 22b. SIGNATURE<br><u>David C. Allen</u> MD   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   | 22c. DATE SIGNED<br>11/26/80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DAVID C. ALLEN, M.D.  |  | 22e. ADDRESS<br>UNION MEMORIAL HOSPITAL   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   | 23b. DATE<br>11/28/80  | 23c. NAME OF CEMETERY OR CREMATORY<br>MT. CARMEL  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>QUEENS, L.I. N.Y.                       |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>SOL LEVINSON & BROS.   |  | 6010 REISTERSTOWN RD.<br>BALTIMORE, MD. (21215)   |   | 25a. DATE REC'D. BY REGISTRAR<br>DEC 3 1980   | 25b. REGISTRAR'S SIGNATURE<br><u>Anthony Delaney</u>   |

THE UNIVERSITY OF CHICAGO  
LIBRARY  
CHICAGO, ILL.

85 00



*[Faint handwritten text]*



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE GIVEN TO THE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |   |  |  |  |  |  |   |  | REG. NO. 70 28101  |  |  |  |   |  |
|--|--|---|--|--|--|--|--|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  | 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Bernice S. Grace</b> |  |  |  |  |  |   |  | 2a. DATE KNOWN OF DEATH<br>MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/><br><b>11 10 19 80</b> |  | 2b. HOUR<br>M <input type="checkbox"/> AM <input type="checkbox"/><br><b>1:17</b>        |  |   |  |
| 3. SEX<br><b>female</b>  |  | 4. RACE<br><b>black</b>                                     |  | 5. DATE OF BIRTH<br>MONTH <b>6</b> DAY <b>15</b> YEAR <b>23</b>  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>57</b> YRS.                                      |  | IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>  |  | IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>  |  | 2c. DATE PRONOUNCED DEAD<br>MONTH <b>11</b> DAY <b>10</b> YEAR <b>19 80</b>              |  | 2d. HOUR<br>M <input type="checkbox"/> AM <input type="checkbox"/><br><b>1:17</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>   |  |   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                        |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  |   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University Hospital</b> |  |  |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>MD</b>  |  |   |  | 13b. COUNTY<br><b>Baltimore</b>  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  | 13e. STREET ADDRESS<br><b>908 N. Stricker St.</b>  |  |   |  |
| 14. FATHER'S NAME<br>FIRST <b>Elzie</b> MIDDLE <b>Snowden</b> LAST <b>Snowden</b>  |  |   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Eliza</b> MIDDLE <b>Harrod</b> LAST <b>Harrod</b> |  |   |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>   |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>218-18-4172</b>   |  |  |  | 17. INFORMANT<br><b>Elzie Snowden</b>   |  |  |  | ADDRESS<br><b>908 N. Stricker St.</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Subarachnoid hematoma</b><br>4300<br>(b) <b>Rupture of berry aneurysm</b><br>(c) <b>DUE TO, OR AS A CONSEQUENCE OF</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |  |   |  |  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |   |  |  |  |  |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |   |  |  |  | 20. AUTOPSY? (HO)<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>(Head Only)</b>   |  |  |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |   |  |  |  |  |  |   |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE<br><i>[Signature]</i>   |  |   |  | TITLE (SPECIFY)<br><b>Assistant</b>  |  |  |  | MEDICAL EXAMINER<br>M.D.  |  |  |  | DATE SIGNED<br><b>11/11/80</b>   |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Hormez R. Guard, M.D.</b>   |  |   |  | ADDRESS<br><b>111 Penn Street, Baltimore, MD 21201</b>   |  |  |  |   |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |   |  | 23b. DATE<br><b>11/17/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Calvary Cem.</b>                          |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co. MD</b>  |  |  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>  |  |   |  | ADDRESS<br><b>1101 E. North Ave.</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 12 1980</b>   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |   |  |

150-1115

10-10

10-10

10-10

10-10

10-10

10-10

10-10

10-10

10-10

10-10

10-10

10-10

10-10

10-10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

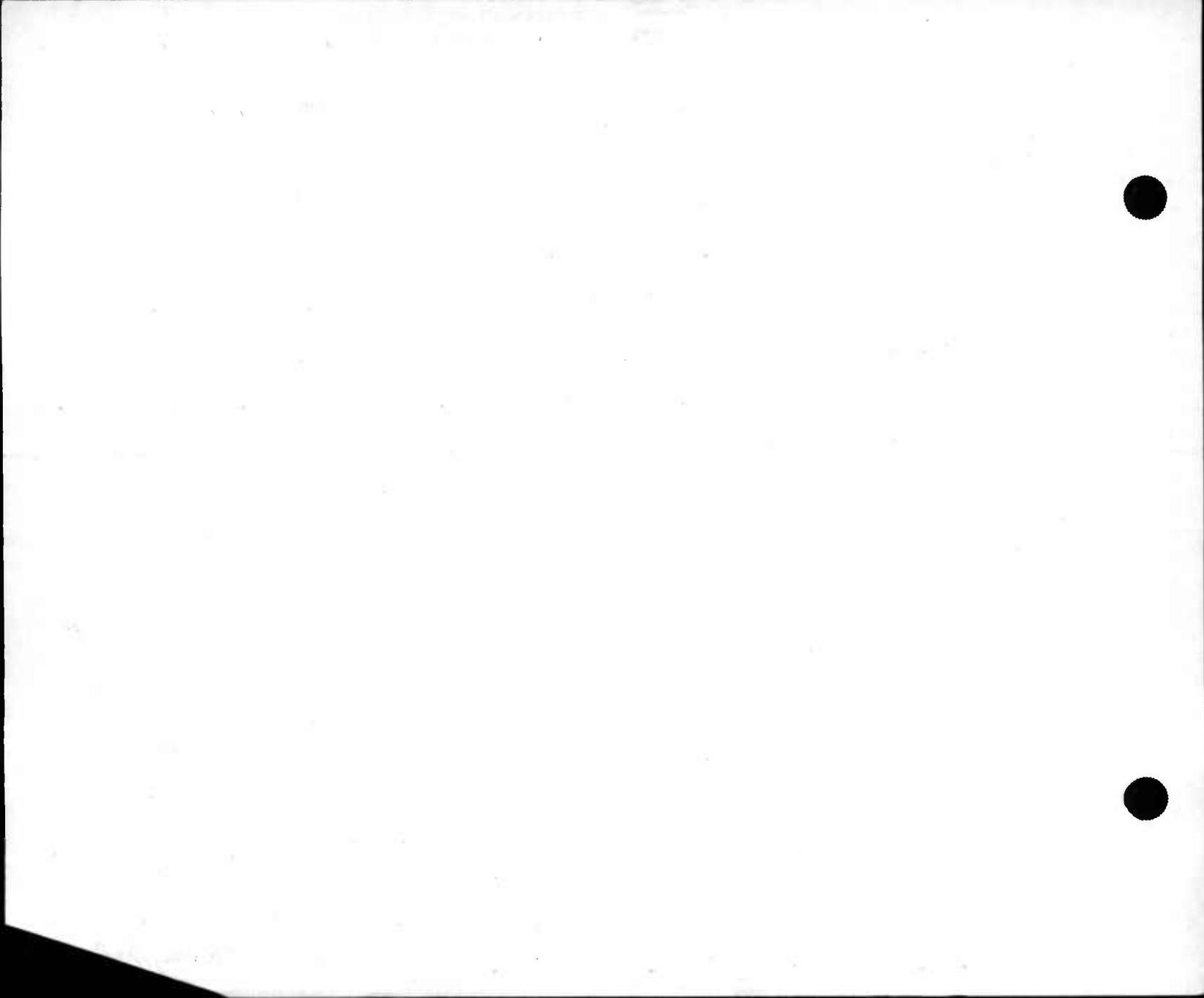
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 1 0 2

REG. NO.

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  | 2b. HOUR   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST  |  | November 13 1980  |  | M  |  |
| 3. SEX Male   |  | 4. RACE Negro   |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY) 49  |  | 7. CITIZEN OF WHAT COUNTRY? USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD   |  | 10. CITY OR TOWN OF DEATH Baltimore                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 17 N. Culver St.                                  |  |
| 12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 13. STREET ADDRESS 17 N. Culver St.                                       |  | 14. KIND OF BUSINESS OR INDUSTRY   |  |
| 15. FATHER'S NAME FIRST MIDDLE LAST David Graham  |  | 16. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna L. Pye                    |  | 17. SOCIAL SECURITY NO. 213-28-4313  |  |
| 18. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes  |  | 19. INFORMANT ADDRESS Anna L. Graham 201 N. Broadway St.                  |  | 20. DATE OF OPERATION  |  |
| 21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4029   |  | 22. DUE TO, OR AS A CONSEQUENCE OF (b) Auto Cordial Myocardial Infarction |  | 23. DUE TO, OR AS A CONSEQUENCE OF (c) Myocardial Infarction   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |
| 24. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 25. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                       |  | 26. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |
| 27. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK   |  | 28. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)        |  | 29. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |
| 30. I certify that (I) (this hospital) attended the deceased from 11/20/80, 1980, to 11/30, 1980, that (I) (we) last saw the deceased alive on 11/20/80, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |
| 31. SIGNATURE d. Borofsky M.D.  |  | 32. DEGREE  |  | 33. DATE SIGNED 12/2/80  |  |
| 34. PHYSICIAN'S NAME (TYPE OR PRINT) SBOROFsky  |  | 35. ADDRESS 4734 Palmdale Ave 21215                                       |  | 36. DATE REC'D. BY REGISTRAR 12/4 1980   |  |
| 37. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial   |  | 38. DATE 12/5/80  |  | 39. NAME OF CEMETERY OR CREMATORY Western Star Cem.  |  |
| 40. FUNERAL DIRECTOR NAME Wm. C. March F/H  |  | 41. ADDRESS 1101 E. North Ave.  |  | 42. DATE REC'D. BY REGISTRAR 12/4 1980   |  |





#526 Per PH W/ FH mk  
1 - STATE REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 1 0 3

REG. NO.

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>John Greenham   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 25 80                               |  | 2b. HOUR<br>10:54 AM   |
| 3. SEX<br>Male  | 4. RACE<br>Black   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2/29 1983   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>87 86 YRS                                  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>PA   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                     |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTO.   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Lutheran Hospital of MD |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Custodian |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br>MD  |  |   | 13b. COUNTY<br>MD   | 13c. CITY OR TOWN<br>Baltimore   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>UNK   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>UNK                          |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.<br>19803 8793  |   | 17. INFORMANT<br>Gail Crawley 837 Augusta Ave.                                       |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) Gram negative pneumonia<br>4360<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) Stroke<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>DUE TO, OR AS A CONSEQUENCE OF |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/25/80, 19, to 11/25/80, 19, that (I) (we) last saw the deceased alive on 11/25/80, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.                                     |  |   |   |  |  |
| 22b. SIGNATURE<br>E. Schaefer MD  |  |   |   | 22c. DATE SIGNED<br>11/25/80   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>E Schaefer MD.   |  |   |   | 22e. ADDRESS<br>LUTHERAN HOSPITAL  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>11/28/80   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn Cem.                                |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>C. Powell F.H. 2nd  |  | ADDRESS<br>319 N. Schroeder   |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 28 1980   |  |
| 25b. REGISTRAR'S SIGNATURE<br>R. J. [Signature]   |  |   |   |  |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 15 days of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 28104

REG. NO.

|  |   |   |  |   |   |
|--|---|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>ZOA C. GRAUEL  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 3, 1980  |   | 2b. HOUR<br>5:30 P<br>M   |
| 3. SEX<br>Female   | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Oct. 29, 1885   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>95 YRS.   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Indiana   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |   |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1814 Ingram Road |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home                       |   |
| 13a. STATE<br>Maryland   |   |   | 13b. COUNTY  | 13c. CITY OR TOWN<br>Baltimore                                      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Alfred Redman  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Laura ?   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>217 48 0062  | 17. INFORMANT<br>ADDRESS<br>Miss Esther C. Grauel   |  | Same  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) _____<br>4140 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>extensive heart disease</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____ |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Myocardial Infarction</i>   |   |   |  |   |   |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |
| 22a. I certify that (I) (this hospital attended the deceased from 3-11-1964 to 10-28-1980, that (I) (we) lost saw the deceased alive on 10-28-1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |   |   |  |   |   |
| 22b. SIGNATURE<br><i>Dr. Sebastian Russo</i>   |   | DEGREE  | 22c. DATE SIGNED<br>11/4/80  |   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Sebastian Russo, M.D.   |   | 22e. ADDRESS<br>5122 Harford Road, Balto., Md.  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   | 23b. DATE<br>11/6/80  | 23c. NAME OF CEMETERY OR CREMATORY<br>Woodlawn Cemetery   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Woodlawn, Maryland   |   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., Md. 21212  |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 6 1980   | 25b. REGISTRAR'S SIGNATURE<br><i>Robert McCreedy</i>   |   |   |

MEDICAL CERTIFICATION

BP

800 York Road, Baltimore, Md. 21212  
Henry W. Jenkins & Sons Co.

Unit 11, 1150 Woodlawn Cemetery, Woodlawn, Maryland

Dr. Sebastian Russo, M.D., 5122 Harbor Road, Baltimore, Md.

x

W. J. Jenkins

x

No 217 40 0000 Miss Esther C. Grunel Same

Frederick Laura

Maryland Baltimore x 1914 Indiana Ford

1914 Indiana Ford Homeless Own Home

Indiana U A x Baltimore City

White 25 25 1935 25

25 25 1935 25 25 1935 25



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8028105

REG. NO.

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1 - FOR STATE REGISTRAR <u>GRACE</u>   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><u>11-23-80</u>   |  | 2b. HOUR<br><u>10:00</u> AM  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><u>GRACE V GRAY</u>   |  | 3 SEX<br><u>F</u>   |  | 4 RACE<br><u>B</u>   |  |
| 5 DATE OF BIRTH MONTH DAY YEAR<br><u>12 08 95</u>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><u>84</u> YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>M.D.</u>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |
| 9 BALTIMORE CITY OR COUNTY OF DEATH<br><u>CITY</u>   |  | 10 CITY OR TOWN OF DEATH<br><u>BALTIMORE</u>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>LUTHERAN HOSPITAL</u>  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  | 13a. STREET ADDRESS<br><u>721 N. Carey St.</u>   |  |
| 13b. COUNTY<br><u>MD</u>   |  | 13c. CITY OR TOWN<br><u>BALTIMORE</u>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><u>John Bailey</u>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><u>Harriet Bailey</u>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><u>No</u>   |  |
| 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><u>213052699</u>  |  | 17 INFORMANT ADDRESS<br><u>Ellwood Anderson 721 N. Carey St.</u>  |  | 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Adino Ca. of the Colon.</u><br><u>1539</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).<br><u>Unl. fever</u> |  |
| 19a. DATE OF OPERATION<br><u>11-23-80</u>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><u>19</u>  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  | 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  | 22a. I certify that (I) (this hospital) attended the deceased from <u>11-23-80</u> to <u>11-23-80</u> , that (I/we) last saw the deceased alive on <u>11-23-80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I/we) (did) (did not) view the body after death. |  | 22b. SIGNATURE<br><u>Sissas Awke</u>   |  |
| 22c. DATE SIGNED<br><u>11-23-80</u>  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>SISSAS Awke</u>   |  | 22e. ADDRESS<br><u>Futheer Hospital</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>   |  | 23b. DATE<br><u>11/28/80</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Mt. Auburn Cem.</u>   |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE<br><u>Baltimore MD</u>   |  | 24 FUNERAL DIRECTOR NAME<br><u>Wm. C. March F/H</u>   |  | 25. DATE REC'D. BY REGISTRAR<br><u>NOV 25 1980</u>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>Esther K. Keady</u>   |  | 26. ADDRESS<br><u>1101 E. North Ave.</u>  |  | 27. DATE REC'D. BY REGISTRAR<br><u>NOV 25 1980</u>   |  |



*Handwritten signature*

MOAS 2 100

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

|  |  |                  |                 |  |  |  |  |   |               |  |  |   |  |  |                        |                                   |  |   |  |
|--|--|------------------|-----------------|--|--|--|--|---|---------------|--|--|---|--|--|------------------------|-----------------------------------|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |                  | FIRST<br>Gerard |  |  | MIDDLE<br>J.   |  |   | LAST<br>Green |  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>MONTH DAY YEAR<br>11 23 19 80 |  |  | 2b. HOUR<br>M<br>8:45A |                                   |  |   |  |
| 3. SEX<br>male   |  | 4. RACE<br>black |                 | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 18 80  |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>YRS.<br>25           |  | IF UNDER 1 YR.<br>MONTHS DAYS<br>2 5  |               | IF UNDER 24 HRS.<br>HOURS MIN.<br>8 45                     |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>11 23 19 80             |  |  | 2d. HOUR<br>M<br>8:45A |                                   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD  |  |                  |                 | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |               |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.            |  |  |                        |                                   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |                  |                 | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>South Baltimore General Hosp |  |  |  |   |               |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)         |  |  |                        | 12b. KIND OF BUSINESS OR INDUSTRY |  |   |  |
| 13a. STATE<br>MD   |  |                  |                 |  |  |  |  |   |               | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. STREET ADDRESS<br>3421 Spellman Rd.     |                        |                                   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Jerome Green   |  |                  |                 |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Sheila Ross |  |   |               |  |  |   |  |  |                        |                                   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |  |                  |                 | 16b. SOCIAL SECURITY NO.<br>N/A  |  |  |  | 17. INFORMANT ADDRESS<br>Sheila Ross 3421 Spellman Rd.  |               |  |  |   |  |  |                        |                                   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>3229 IMMEDIATE CAUSE (a) <del>Sudden Infant death syndrome</del> Meningitis<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |  |                  |                 |  |  |  |  |   |               |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                        |                                   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.  |  |                  |                 |  |  |  |  |   |               |  |  |   |  |  |                        |                                   |  |   |  |
| 19a. DATE OF OPERATION   |  |                  |                 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |   |               |  |  |   |  |  |                        |                                   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |                 | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |               |  |  |   |  |  |                        |                                   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |                  |                 | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |               |  |  |   |  |  |                        |                                   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                  |                 |  |  |  |  |   |               |  |  |   |  |  |                        |                                   |  |   |  |
| ACTUAL SIGNATURE<br><i>Hormez R. Guard</i>   |  |                  |                 | TITLE (SPECIFY)<br>Assistant   |  |  |  | DATE SIGNED<br>11/24/80   |               |  |  | MEDICAL EXAMINER  |  |  |                        |                                   |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Hormez R. Guard, M.D.  |  |                  |                 | ADDRESS<br>111 Penn Street, Balto., MD 21201   |  |  |  |   |               |  |  |   |  |  |                        |                                   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |                  |                 | 23b. DATE<br>11/26/80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn Cem.        |  |   |               | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore MD |  |   |  |  |                        |                                   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H   |  |                  |                 | ADDRESS<br>1101 E. North Ave.  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 25 1980  |               |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Robert H. Harty</i>                  |  |  |                        |                                   |  |   |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE AGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

NOV 2 1945

NOV 2 1945

05L/3  
ARYLAND 21201

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH-16 30M 2/80  
(VRA 15, 4)

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after the death. Please return it to the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If Item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

8028107

REG. NO.

1 - STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)

FIRST

James

MIDDLE

L.

LAST

Green

2a. DATE OF DEATH

MONTH

November

DAY

28

YEAR

1980

2b. HOUR

4:30

PM

3. SEX

male

4. RACE

Black

5. DATE OF BIRTH

MONTH

June

DAY

1

YEAR

1892

6. AGE (IN YEARS LAST BIRTHDAY)

88

YRS.

7a. BIRTHPLACE (COUNTRY)

STATE OR FOREIGN

7b. CITIZEN OF WHAT COUNTRY?

U.S.

8. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City

MD.

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

The Johns Hopkins Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OR WORKING LIFE)

RETIRED

12b. KIND OF BUSINESS OR INDUSTRY

NONE

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Md.

13b. COUNTY

Balto.

13c. INSIDE CITY LIMITS?

YES ☐ NO ☐

13d. STREET ADDRESS

601 N. Broadway

14. FATHER'S NAME

FIRST

unk.

MIDDLE

LAST

15. MOTHER'S MAIDEN NAME

FIRST

unk.

MIDDLE

LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

no

16b. SOCIAL SECURITY NO.

N/A

17. INFORMANT

Margaret Marshall

ADDRESS

4413 Wentworth Rd.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

respiratory arrest

1629

CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.

(b)

Squamous cell ca of lung

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR

A.M.

MONTH

DAY

YEAR

P.M.

19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 11/25/80 19 to 11/28/80, that (I) (we) lost saw the deceased alive on 11/28/80 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒

22c. DATE SIGNED

11/28/80

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

Robert L. Redner MD

Johns Hopkins Hosp. Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION

CITY OR TOWN

COUNTY

STATE

24. FUNERAL DIRECTOR

25a. DATE REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

Burial

12/1/80

King Memorial Pk.

Balto., Md.

DEC 1 1980

Robert L. Redner

48 001  
12 10 40



DEC 1 1940

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXCISE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

3

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

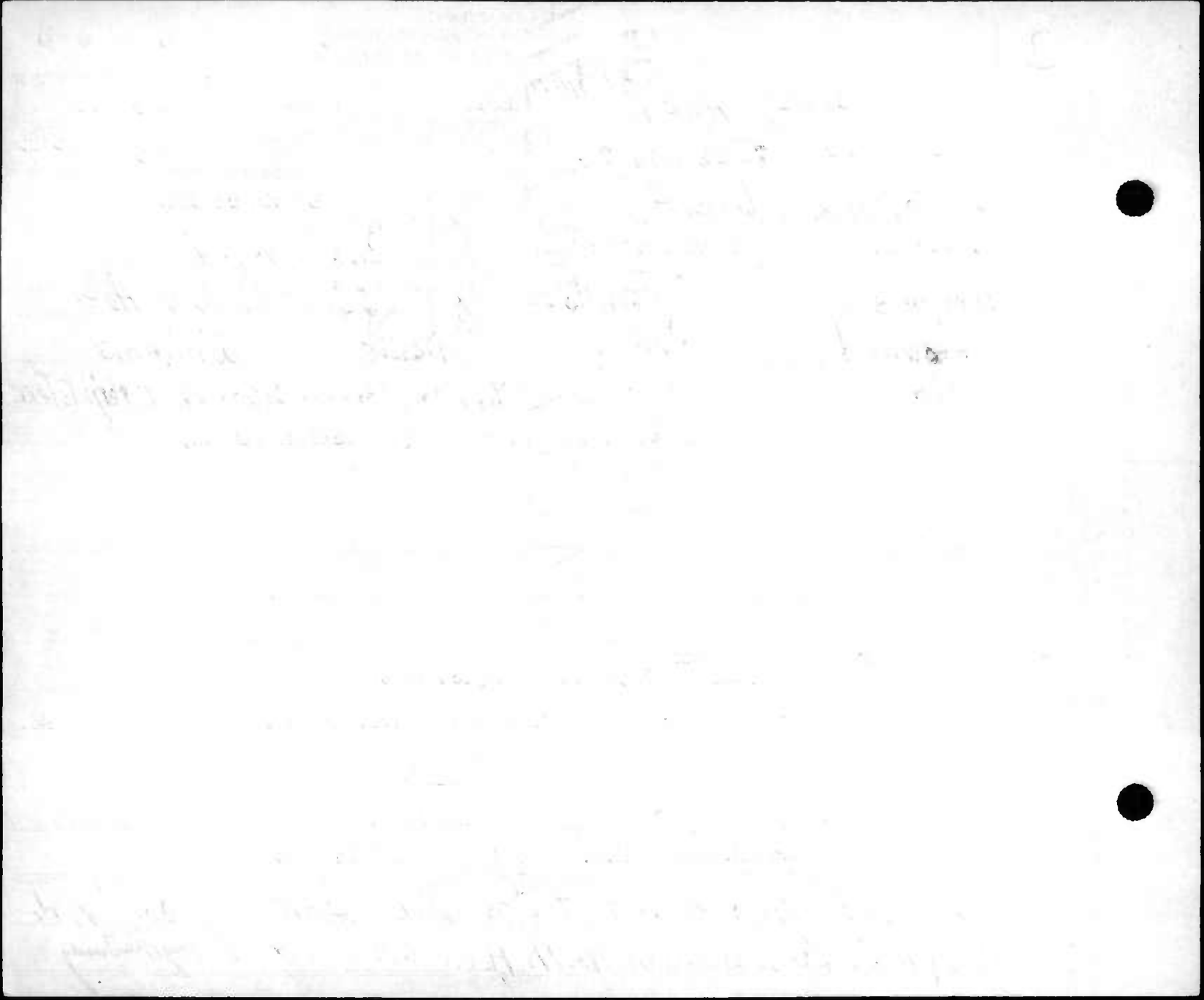
FOR  
1- STATE  
REGISTRAR

|  |                  |   |  |   |  |   |  |  |  |   |  |
|--|------------------|---|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |                  | FIRST<br>SIDNEY   |  | MIDDLE<br>ALLEN   |  | LAST<br>GREEN   |  | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br>11 5 80 |  | 2b. HOUR<br>M<br>5:35                                 |  |
| 3. SEX<br>male   | 4. RACE<br>negro | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8-28-1954   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>26 YRS.   |  | IF UNDER 1 YR.<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.                       |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>11 5 80 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Balto, Md.  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NONE IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Provident Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Unemployed                     |  | 12b. KIND OF BUSINESS OR INDUSTRY                    |  |   |  |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>Maryland  |                  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Balto.   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>2608 Roslyn Ave.              |  |   |  |
| 14. FATHER'S NAME<br>Leonard   |                  | MIDDLE<br>Green   |  | LAST<br>Green   |  | 15. MOTHER'S MAIDEN NAME<br>Doris   |  | MIDDLE<br>Williams                                   |  | LAST<br>Williams                                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>NO  |                  | 16b. SOCIAL SECURITY NO.<br>217-12-2139   |  | 17. INFORMANT<br>Mrs. Doris Green   |  | ADDRESS<br>2508 Park Heights Ave.   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY: Multiple gunshot wounds (unspecified weapon)<br>9654 IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |                  |   |  |   |  |   |  |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |                  |   |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  |  |  |   |  |
| 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                  |   |  |   |  |   |  |  |  |   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                  | 21b. TIME OF INJURY<br>HOUR MIN. MONTH DAY YEAR<br>8:25 P.M. 11-5-80  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>Subject shot.  |  |   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>   |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>house  |  | 21f. LOCATION<br>STREET<br>2608 Roslyn Ave., Balto.   |  | CITY OR TOWN<br>Balto.  |  | COUNTY   |  | STATE<br>Md.  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                  |   |  |   |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE<br>Ann M. Dixon   |                  | TITLE (SPECIFY)<br>Assistant  |  | MEDICAL EXAMINER  |  |   |  | DATE SIGNED<br>11-6-80                               |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Ann M. Dixon, M.D.   |                  | ADDRESS<br>111 Penn St.   |  |   |  |   |  |  |  |   |  |
| 23a. BURIAL CREMATION REMOVAL<br>Burial  |                  | 23b. DATE<br>11-10-80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Memorial Park   |  | 23d. LOCATION<br>City or town<br>Balto.   |  | COUNTY<br>Co.  |  | STATE<br>Md.  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Joseph L. Reuss  |                  | ADDRESS<br>2222 W. North Ave.   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 7 1980   |  | 25b. REGISTRAR'S SIGNATURE<br>R. J. Reuss   |  |  |  |   |  |

BP

DHMH-17  
(VR A15 ME (5))  
15M 2/80

1538





STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

2 8 1 0 9

REG. NO.

FOR  
STATE  
REGISTRAR

|  |  |   |   |   |                            |  |  |
|--|--|---|---|---|----------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>William Greene</i>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>11 6 80</i> |   | 2b. HOUR<br><i>3:10 PM</i> |  |  |
| 1. SEX<br><i>male</i>  |  | 4. RACE<br><i>Black</i>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>5 14 20</i>  |                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS HOURS MIN.<br><i>60</i>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Balto., Md.</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>yes</i>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Provident</i> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Retired</i>  |                            | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><i>Balto. Md.</i>  |  | 13b. COUNTY<br><i>US</i>  |   | 13c. CITY OR TOWN<br><i>Balto.</i>  |                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 13e. STREET ADDRESS<br><i>4106 Ethland Ave.</i>  |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Lee Greene</i>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Ethel Bailey</i>  |                            |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>yes</i>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>218-03-1508</i>   |   | 17. INFORMANT<br>ADDRESS<br><i>Mrs. Betty M. Greene, 4106 Ethland Ave.</i>  |                            |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardio-respiratory Arrest</i><br><i>4280</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Renal Failure</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) <i>Congestive Failure</i> |  |   |   |   |                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><i>Diabetes Mellitus</i>   |  |   |   |   |                            |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                            |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                            |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |   |   |                            |  |  |
| 22b. SIGNATURE<br><i>[Signature]</i>   |  |   |   | DEGREE<br><i>MD</i>   |                            | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Ollivant S. Jones</i>  |  |   |   | 22e. ADDRESS<br><i>Provident Hosp</i>   |                            |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>   |  | 23b. DATE<br><i>11/10/80</i>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Arbutus Memorial Pk</i>  |                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Arbutus Md.</i>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Leroy O. Dyett</i>  |  |   |   | ADDRESS<br><i>4600 Liberty Heights Ave.</i>   |                            | 25a. DATE REC'D. BY REGISTRAR<br><i>NOV 12 1980</i>  |  |
|  |  |   |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |                            |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Possession may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

ROYAL SOCIETY

1880

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |  |  | REG. NO.   |  |                       |  |
|--|--|---|--|---|--|--|--|--|--|--|--|-----------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>ROSE H. GREENFIELD  |  |   |  |   |  |  |  |  |  | DATE OF DEATH MONTH DAY YEAR<br>11/04/80               |  | 2b. HOUR<br>5:15 P.M. |  |
| 3. SEX<br>Female   |  | 4. RACE<br>CAUCASIAN  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>12 08 06   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>73 YRS.   |  | 7. UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  | 8. UNDER 24 HRS.                                       |  |                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>ILLINOIS  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                           |  |  |  |  |  |                       |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Sinai hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE        |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>AT HOME   |  |  |  |                       |  |
| 13a. STATE<br>ILLINOIS   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>CHICAGO  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>2643 FITCH  |  | #60645   |  |                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>HARRIS ELFORD  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ANN UNKNOWN  |  |  |  |  |  |  |  |                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>344-24-6742  |  | 17. INFORMANT<br>MRS. DARYL WORSEY  |  | 4076 ARJAY   |  | 21043  |  |  |  |                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>respiratory cardiac arrest</u><br>5860<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>CHF, renal failure, diabetes</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>renal failure, diabetes</u> |  |   |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 year |  |                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |  |  |  |  |  |                       |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |  |  |                       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |                       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |  |  |  |  |                       |  |
| 22b. SIGNATURE<br>Marek Suchowiechy  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |  |  | 22c. DATE SIGNED<br>11/4/80  |  |  |  |                       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MORDO SUCHOWIECHY   |  |   |  | 22e. ADDRESS<br>SINAI HOSP.   |  |  |  |  |  |  |  |                       |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>REMOVAL/BURIAL  |  | 23b. DATE<br>11/7/80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>SHALOM MEM. PARK  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>PALATINE ILLINOIS                      |  |  |  |  |  |                       |  |
| 24. FUNERAL DIRECTOR<br>NAME SOL LEVINSON & BROS., INC.<br>6010 REISTERSTOWN RD. BALTO., MD 21215  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 12 1980   |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |  |  |                       |  |

BP

ST. LOUIS, MO., 1912

1912

1912

1912

1912

1912

1912

1912

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

28111

|   |                         |  |  |   |                  |   |                              |   |  |
|---|-------------------------|--|--|---|------------------|---|------------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Shirley Gregory</b>   |                         |  |  | 2a. DATE KNOWN OF DEATH<br>ESTI- MATED <input checked="" type="checkbox"/> 11 12 1980   |                  |   |                              | 2b. HOUR<br>M   |  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>Black</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>unk.</b>  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)<br><b>80 ? YRS.</b> | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>11 13 1980</b>                                 | 7d. HOUR<br><b>1:11 p.m.</b> |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Mississippi</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |                              |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>5300 Norwood Avenue</b> |  |   |                  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>retired</b>                 |                              | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>Md</b>   |                         | 13b. COUNTY<br><b>DALTON CITY</b>  |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |                  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                              | 13e. STREET ADDRESS<br><b>5300 Norwood Ave.</b>                                     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>unk.</b>   |                         |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unk.</b>  |                  |   |                              |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>  |                         | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>None</b>   |  | 17. INFORMANT ADDRESS<br><b>Mrs. Patricia Low 5520 Groveland Ave.</b>   |                  |   |                              |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b><br>4292<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |                         |  |  |   |                  |   |                              |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |                         |  |  |   |                  |   |                              |   |  |
| 19a. DATE OF OPERATION  |                         |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |                  |   |                              | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |                              |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |                         |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |                  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                              |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                         |  |  |   |                  |   |                              |   |  |
| ACTUAL SIGNATURE<br><i>Margarita A. Korell</i>  |                         |  |  | TITLE (SPECIFY)<br><b>Assistant</b>   |                  |   |                              | DATE SIGNED<br><b>11-14-80</b>  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Margarita A. Korell, M.D.</b>  |                         |  |  | ADDRESS<br><b>111 Penn Street</b>   |                  |   |                              |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |                         | 23b. DATE<br><b>11/17/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Memorial Pk.</b>  |                  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b>                                 |                              |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leroy O. Dyett</b>   |                         |  |  | ADDRESS<br><b>4600 Liberty Heights Ave.</b>   |                  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 17 1980</b>   |                              | 25b. REGISTRAR'S SIGNATURE<br><i>Rita K. K...</i>                                   |  |



6

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

2 8 1 1 2

REG. NO.

|  |   |  |  |   |   |
|--|---|--|--|---|---|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>Ann Eleanor Gross  |   |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>11/24/80                               |   | 2b HOUR<br>305 PM   |
| 3 SEX<br>Female  | 4 RACE<br>Black   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>March 18, 1901  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>79  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Calvert Co. Md.  | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE City MD.                     |   |
| 10 CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Provident Hospital |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker |   | 12b KIND OF BUSINESS OR INDUSTRY<br>Home  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br>Maryland   |   |  | 13b COUNTY   | 13c CITY OR TOWN<br>Baltimore   | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Hezekiah Gross  |   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ann Muriel Johnson           |   |   |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>219-12-5113   | 17 INFORMANT ADDRESS<br>21215<br>Clarence F. Gross-3402 Springdale Ave   |  |   |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardio-Respiratory Arrest<br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Myocardial Infarction<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)   |   |  |  |   |   |
| 19a DATE OF OPERATION  |   | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |
| 22a I certify that (I) (this hospital) attended the deceased from 11/21, 1980, to 11/24, 1980 that (I) (we) last saw the deceased alive on 11/24, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |   |  |  |   |   |
| 22b SIGNATURE<br>O. S. Jones MD  |   | DEGREE   |  | 22c DATE SIGNED<br>11/24/80   |   |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>O. S. Jones  |   | 22e ADDRESS<br>Provident Hosp  |  |   |   |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   | 23b DATE<br>11/28/1980  | 23c NAME OF CEMETERY OR CREMATORY<br>Arbutus Mem. Park   |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Co. Maryland           |   |
| 24 FUNERAL DIRECTOR<br>NAME<br>Herbert E. Nutter-0035 W. North Ave.  |   | 25a DATE REC'D. BY REGISTRAR<br>NOV 26 1980  |  | 25b REGISTRAR'S SIGNATURE<br>[Signature]                                      |   |

MEDICAL CERTIFICATION

99

1506 BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1 - FOR STATE REGISTRAR   |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8 0 2 8 1 1 3<br>REG. NO.  |  |  |  |
|---|--|---|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>FREDA GROSS   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>NOVEMBER 9, 1980   |  |  |  | 2b. HOUR<br>12 <sup>40</sup> P.M.  |  |  |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>SEPT. 1887  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>93 YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |  | 7b. IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>POLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                           |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>PALL MALL NURSING HOME |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE        |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>AT HOME   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE MARYLAND 13b. COUNTY BALTIMORE 13c. CITY OR TOWN BALTIMORE   |  |   |  |   |  |  |  |  |  |  |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS<br>4111 ESSEX RD.   |  |   |  | 13f. #21207  |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>MEYER PIEKARZ   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>RACHAL UNKNOWN   |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO  |  |   |  | 16b. SOCIAL SECURITY NO.<br>213-60-3151   |  | 17. INFORMANT<br>ADDRESS<br>MRS. LILLIAN WEINBERG<br>4111 ESSEX RD. BALTO., MD 21207 |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <i>Acute pulmonary edema - cardiac arrest</i><br>4140 X DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <i>Arteriosclerotic Heart Disease</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 day<br>5 years |  |   |  |   |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):<br><i>Rheumatoid arthritis</i>   |  |   |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 2 1975</i> to <i>Nov 9 1980</i> , that (I) (we) last saw the deceased alive on <i>Nov 9 1980</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><i>Manuel Levin M.D.</i>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |  |  | 22c. DATE SIGNED<br>11/10/80   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. MANUEL LEVIN   |  |   |  | 22e. ADDRESS<br>6101 PARK HTS. AVE. BALTO., MD  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  | 23b. DATE<br>NOV. 11, 1980  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>PETAACH TIKVAH  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>ROSEDALE BALTO., MD                    |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>SOL LEVINSON & BROS., INC.<br>6010 REISTERSTOWN RD. BALTO., MD 21215  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 12 1980  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Robert H. [Signature]</i>                           |  |  |  |  |  |

57

— 1000000 —

1000000

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE **8 0 2 8 1 1 4**  
CERTIFICATE OF DEATH

|  |  |  |  |
|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | 2a. DATE OF DEATH  |  |
| FIRST MIDDLE LAST<br><b>Thomas R. Grover</b>   |  | MONTH DAY YEAR<br><b>November 07, 1980</b>   |  |
| 3. SEX   |  | 2b. HOUR   |  |
| <b>Male</b>  |  | <b>12:39p</b>  |  |
| 4. RACE  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  |
| <b>White</b>   |  | <b>63</b> YRS.   |  |
| 5. DATE OF BIRTH   |  | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |
| MONTH DAY YEAR<br><b>June 29, 1917</b>   |  | <b>Md.</b>   |  |
| 8. CITIZEN OF WHAT COUNTRY?  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |
| <b>USA</b>   |  | <b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |
| <b>Baltimore</b>   |  | <b>The Johns Hopkins Hospital</b>  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| <b>Meat Cutter</b>   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |
| 13b. STATE 13c. COUNTY 13d. CITY OR TOWN 13e. STREET ADDRESS   |  |  |  |
| <b>Md. Baltimore 1378 Pentwood Rd.</b>   |  |  |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  |
| FIRST MIDDLE LAST<br><b>Frank Grover</b>   |  | FIRST MIDDLE LAST<br><b>Carrie Webster</b>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  |
| <b>yes</b>   |  | <b>WW 2 219-12-5456</b>  |  |
| 17. INFORMANT ADDRESS  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))                               |  |
| <b>Mrs. Catherine B. Grover same</b>   |  | PART I. DEATH WAS CAUSED BY:   |  |
|  |  | IMMEDIATE CAUSE (a) <b>cardiopulmonary arrest</b>  |  |
|  |  | DUE TO, OR AS A CONSEQUENCE OF (b) <b>cardiogenic shock</b>  |  |
|  |  | DUE TO, OR AS A CONSEQUENCE OF (c) <b>ischemic heart disease</b>                                       |  |
|  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
|  |  | <b>30 minutes</b>  |  |
|  |  | <b>10 LB</b>   |  |
|  |  | <b>16 years</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |  |  |  |
|  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| <b>—</b>   |  | <b>—</b>   |  |
| 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?   |  |
| YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                    |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY  |  |
| <input type="checkbox"/>   |  | HOUR A.M. MONTH DAY YEAR<br><b>— — — 19</b>  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  | 21d. INJURY OCCURRED   |  |
| <b>—</b>   |  | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                      |  |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION  |  |
| <b>—</b>   |  | CITY OR TOWN COUNTY STATE<br><b>— — —</b>  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>11-7-80</b> to <b>11-7-80</b> , the (1) (we) lost above, (1) (we) (did) (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE   |  | 22c. DATE SIGNED   |  |
| <b>Peter Rock</b>  |  | <b>11-7-80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |
| <b>Peter Rock</b>  |  | <b>Johns Hopkins Hospital</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  |
| <b>Burial</b>  |  | <b>Nov. 10, 1980</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION  |  |
| <b>St. Paul Methodist</b>  |  | CITY OR TOWN COUNTY STATE<br><b>Lusby Cslvert</b>  |  |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE REC'D. BY REGISTRAR  |  |
| NAME<br><b>Leonard J. Ruck Inc. Baltimore, Maryland</b>  |  | <b>NOV 10 1980</b>   |  |

THE UNIVERSITY OF CHICAGO  
LIBRARY

LIBRARY OF THE UNIVERSITY OF CHICAGO

1901

1901

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 28115

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |   |   |   |
|---|---|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <u>Michael A. Guerrasio</u>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><u>11 22 80</u>  |   | 2b. HOUR<br><u>7:00am</u>   |
| 3. SEX<br><u>Male</u>   | 4. RACE<br><u>White</u>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><u>June 29, 1905</u>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>75</u> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>Balto. City</u>   | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U S. A</u>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Balto. City</u> MD.                                      |   |   |
| 10. CITY OR TOWN OF DEATH<br><u>Balto.</u>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>St. Agnes</u> | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>Electric Plater</u>  |   | 12b. KIND OF BUSINESS OR INDUSTRY   |   |
| 13a. STATE<br><u>Md.</u>  | 13b. COUNTY<br><u>Balto.</u>  | 13c. CITY OR TOWN<br><u>Catonsville</u>   | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO        | 13e. STREET ADDRESS<br><u>13 Kenwood Ave.</u>   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><u>Anthony Guerrasio</u>  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><u>Elizabeth ? ?</u>                               |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <u>no</u>  |   | 16b. SOCIAL SECURITY NO.<br><u>213 05 2993</u>  | 17. INFORMANT<br><u>Mrs. Genevieve Guerrasio</u> ADDRESS<br><u>13 Kenwood Ave. Balto. Md. 21228</u> |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>SEPSIS</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>POST. RESUSCITATION</u>   |   |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>5 MIN</u><br><u>5 DAYS</u><br><u>12 DAYS</u>                            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>DIABETES MELLITUS, MYOCARDIAL INFARCTION</u>  |   |   |   |   |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <u>19</u>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)        |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                     |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10 NOV</u> , 19 <u>80</u> , to <u>22 NOV</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |   |   |   |   |
| 22b. SIGNATURE<br><u>[Signature]</u>  |   |   |   | 22c. DATE SIGNED<br><u>11/22/80</u>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>ANASTASIO R. DE CASTRO</u>  |   |   |   | 22e. ADDRESS<br><u>900 CATON AVE.</u><br><u>ST. AGNES HOSPITAL BALTIMORE MD 21229</u> |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>Burial</u>   | 23b. DATE<br><u>Nov. 25, 1980</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Lakeview Cem.</u>  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Randa [Signature] Carroll</u> MD.                  |   |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><u>St. Thomas Scherob</u> <u>3512 Frederick Ave Balto</u>   |   |   |   |   |   |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2001.05.01 00:00

viii • Preface

• *Chlorophyll*

note [1] instead.

• C++

• 0.01

045-11-037

DESSAULT

• **Formal** – no other

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |  |   |   |                     |   |  |  |  |                                  |  |
|---|--|--|---|---|---------------------|---|--|--|--|----------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Sybilla E. Haacke |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>November 28, 1980 |   | 2b. HOUR<br>7:00 AM |   |  |  |  |                                  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Aug. 12, 1877   |                     | 6. AGE (IN YEARS LAST BIRTHDAY)<br>103 YRS  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |  | 8. IF UNDER 24 HRS<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Balto. City                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U S A  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                     | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                                       |  |  |  |                                  |  |
| 10. CITY OR TOWN OF DEATH<br>Balto. Md.                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2545 McHenry Street |   |   |                     | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                   |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |                                  |  |
| 13a. STATE<br>Md.   |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br>Balto.   |                     | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>2545 McHenry St.      |  |                                  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Christopher Mueller                 |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Margaretha Ruehl   |                     |   |  |  |  |                                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no    |  | 16b. SOCIAL SECURITY NO.<br>212 32 4231 A  |   | 17. INFORMATION ADDRESS<br>2545 Mc Henry St. Balto. Md. 21223<br>Margaretha L. Kampe  |                     |   |  |  |  |                                  |  |

|   |  |   |  |
|---|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1: DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio Vascular disease</u><br>4292<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>gro. |  |
|---|--|---|--|

PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7-15</u> 19 <u>80</u> to <u>11-28</u> 19 <u>80</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>11-18</u> 19 <u>80</u> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> <u>(did)</u> <u>(do not)</u> view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><u>[Signature]</u>   |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>11/28/80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>HARRY L. KNIPP, M.D.  |  | 22e. ADDRESS<br>5411 OLD FREDERICK Rd. 21229                           |  |  |  |   |  |

|   |  |                           |  |   |  |  |  |
|---|--|---------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                          |  | 23b. DATE<br>Dec. 1, 1980 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Carmel Cem. |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. Md. |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>G. Truman Schwab 3512 Frederick Ave. Balto. Md. |  |                           |  | 25. REGISTRAR'S SIGNATURE<br>[Signature]              |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



U.S. DEPARTMENT OF JUSTICE

Washington, D.C.

Office of the Attorney General

Room 5630

January 10, 1952

Dear Sir:

Enclosed for you are

three copies of

the report of the

Attorney General

dated January 8, 1952.

Very respectfully,  
[Signature]

cc

*[Handwritten signature]*

U.S. DEPARTMENT OF JUSTICE  
January 10, 1952  
[Handwritten notes and stamps at the bottom of the page]



TO HOSPITAL AND ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

80 28117

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |   |   |   |   |   |  |
|--|---|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>JOHN JOHN HAFKO HAFKO                                      |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>NOVEMBER 18, 1980                        |   | 2b. HOUR<br>4:37 AM   |  |
| 3. SEX<br>M -  | 4. RACE<br>W -  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2 4 1924  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>56 YRS.                                      |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pa.   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                      |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Church Home Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>mill-wright |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Bethel-Steel   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland |   |   | 13b. COUNTY<br>Baltimore  | 13c. CITY OR TOWN<br>Baltimore                                    | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Frank Hafko  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Katherine Sass                 |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>yes  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WW 11 128 22 3192  |   | 17. INFORMANT<br>ADDRESS<br>Mrs. Joyce Hafko 8101 Murray Point Rd |   |  |

|  |  |   |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiac Arrest CARDIAC ARREST<br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Ventricular Fibrillation<br>VENTRICULAR FIBRILLATION<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Myocardial Infarction<br>MYOCARDIAL INFARCTION |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from NOVEMBER 12, 1980, NOVEMBER 18, 1980, that (I) (we) last saw the deceased alive on NOVEMBER 18, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br>M70   |  |  |  | DEGREE   |  | 22c. DATE SIGNED<br>11/17/80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MOHAMMAD TAQI, M.D.  |  |  |  | 22e. ADDRESS<br>CHURCH HOSPITAL CORPORATION<br>100 N. BROADWAY, BALTIMORE, MD 21231  |  |   |  |

|   |  |                       |  |   |  |  |  |
|---|--|-----------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation |  | 23b. DATE<br>11/21/80 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Green Mount |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Walter Dabrowski          |  |                       |  | ADDRESS<br>1005 Dundalk Avenue                    |  | 25. DATE REC'D. BY REGISTRAR<br>NOV 21 1980                |  |
|   |  |                       |  | 25b. REGISTRAR'S SIGNATURE<br>L. J. McBrady       |  |  |  |



14. Baltimore  
Church Home Hospital  
Mitt-Wright  
Bethel-Steel  
Baltimore City  
Baltimore  
Baltimore  
Harko  
Lutherline  
Mass  
Mrs. Joyce Harko 8101 Murray Point Rd  
128 12 101  
NW 11

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 1 1 8

REG. NO.

|   |  |   |   |  |                             |  |  |
|---|--|---|---|--|-----------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Marcella V. Hahn</b>  |  |   | 2a. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>13</b> YEAR <b>80</b> |  | 2b. HOUR<br><b>11:35 AM</b> |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br><b>July 12<sup>th</sup> 1913</b>   |                             | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |                             | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore City</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Good Samaritan Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>   |                             | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY   |   | 13c. CITY OR TOWN<br><b>Balt. City</b>   |                             | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST <b>William</b> MIDDLE <b>H.</b> LAST <b>Lewis</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Rosie</b> MIDDLE <b>Ireland</b>  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |                             | 16b. SOCIAL SECURITY NO.<br><b>217-24-4906</b>   |  |
| 17. INFORMANT<br><b>John F. Hahn</b>  |  | ADDRESS<br><b>4006 Wilke Ave. Balt. Md.</b>   |   | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ASCVD, Old MI</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>4100</b> |                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes</b><br><b>4100</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |  |                             |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                             | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)   |                             |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                             |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>9-8-1980</b> to <b>11-13-1980</b> , that (1) (we) lost saw the deceased alive on above, (1) (we) (did) not view the body after death. |  |   |   |  |                             |  |  |
| 22b. SIGNATURE<br><b>Jose ARDAIZ</b>  |  |   |   | DEGREE<br><b>MD</b>  |                             | 22c. DATE SIGNED<br><b>11-13-80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Jose ARDAIZ MD</b>  |  |   |   | 22e. ADDRESS<br><b>7838 EASTERN Ave (21224)</b>  |                             |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Nov. 16, 1980</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Stevensville Cemetery Stevensville</b>  |                             | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J. Ruck, Inc.</b> ADDRESS<br><b>Baltimore, Md.</b>   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 14 1980</b>  |                             | 25b. REGISTRAR'S SIGNATURE<br><b>Robert M. Hahn</b>  |  |

WILLIAMSON  
JAMES W. WILLIAMSON  
1872-1907

11-25-11

mill

allotted



James W. Williamson  
1872-1907

11-25-11  
JAMES W. WILLIAMSON  
1872-1907

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

|  |                  |   |   |   |                  |   |  |
|--|------------------|---|---|---|------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Tom (THOMAS)        |                  | FIRST<br>MIDDLE<br>LAST<br>HAIRSTON   |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>MONTH DAY YEAR<br>11 28 1980  |                  | 2b. HOUR<br>M<br>1:20<br>a M                                  |  |
| 3. SEX<br>male   | 4. RACE<br>negro | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 14 19   | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>61 YRS. | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>11 28 1980      |  |
| 7a. BIRTHPLACE (STATE OR COUNTY)<br>Virginia               |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.    |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                     |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University Hospital |   |   |                  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  |
| 12b. KIND OF BUSINESS OR INDUSTRY                          |                  | 13a. STREET ADDRESS<br>1821 N. Pulaski Street   |   | 13b. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                  | 13c. STREET ADDRESS   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles Hairston |                  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Laura Petty  |   | 16a. HAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |                  |   |  |
| 16b. SOCIAL SECURITY NO.<br>226-10-8595                    |                  | 17. INFORMANT<br>ADDRESS<br>Hattie Hairston 1821 N. Pulaski Street  |   |   |                  |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I DEATH WAS CAUSED BY:

Stab wound of chest

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

9660  
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                         |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>               |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH             |  | 21b. TIME OF INJURY<br>HOURS MIN. MONTH DAY YEAR<br>10:45 P.M. 11-27-1980 |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>Subject stabbed. |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>street     |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>1900 blk. Eutaw Pl., Balto. Md.              |  |

22a. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined manner ☐.

ACTUAL  
SIGNATURE

TITLE (SPECIFY)

Assistant

M.D. MEDICAL EXAMINER

DATE SIGNED 11-28-80

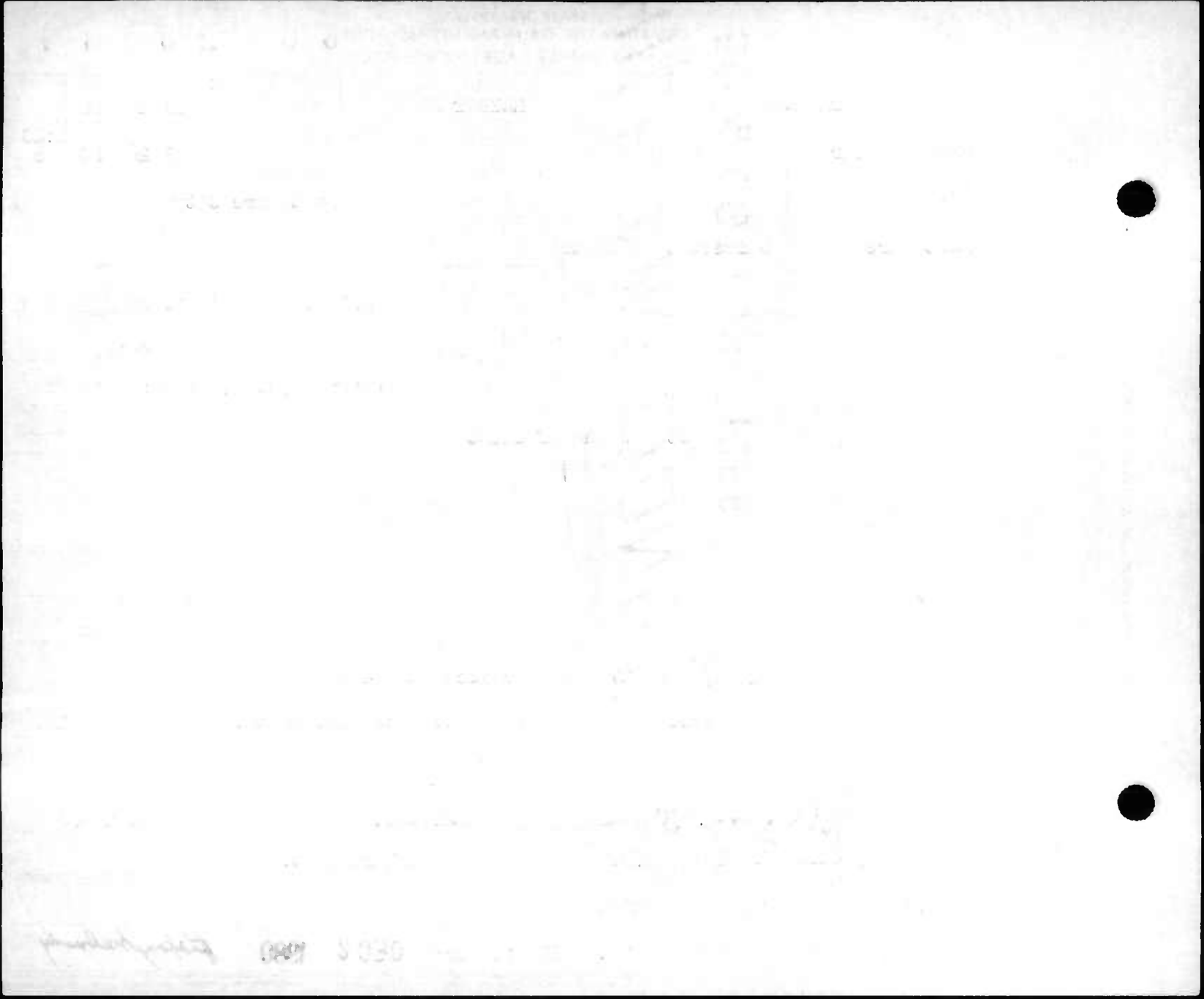
EXAMINER'S NAME  
(TYPE OR PRINT)

Ann M. Dixon, M.D.

ADDRESS

111 Penn St.

|  |                      |   |  |
|--|----------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                       | 23b. DATE<br>12/2/80 | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Memorial Park | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>WILLIAM C. MARCH FUNERAL HOME INC. 1101 E. North Ave |                      | 25a. DATE REC'D. BY REGISTRAR<br>DEC 2 1980                 | 25b. REGISTRAR'S SIGNATURE<br>F. J. H. H. H. |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                         |  |   |  |  |  |  |  | REG. NO. 6028120   |  |
|--|--|-------------------------|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |                         |  |   |  |  |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Andrew J Hall</b>   |  |                         |  |   |  |  |  |  |  | 20. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR<br><b>11 11 80</b>              |  |
| 3. SEX<br><b>male</b>  |  | 4. RACE<br><b>black</b> |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>7 1 24</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>56</b>  |  | IF UNDER 1 YR. MONTHS DAYS<br><b></b>  |  | IF UNDER 24 HRS. HOURS MIN.<br><b></b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>AM Baltimore City</b>                 |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2619 Francis Street</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b></b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b></b>                                     |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                         |  |   |  |  |  |  |  |  |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b></b>  |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>2619 Francis St.</b>   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Unkn</b>   |  |                         |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Unkn</b>                                    |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br><b>No</b>  |  |                         |  | 16b. SOCIAL SECURITY NO.<br><b>220-92-1334</b>  |  | 17. INFORMANT ADDRESS<br><b>Ann Douglas 2619 Francis Street</b>                              |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>4029</b> IMMEDIATE CAUSE (a) <b>Hypertensive cardiovascular disease</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) <b></b><br>(c) <b></b><br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF  |  |                         |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b></b>                          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):<br><b></b>   |  |                         |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b></b>  |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?<br><b></b>  |  |  |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br><b></b>   |  |                         |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)<br><b></b>     |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b></b>  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br><b></b>                                    |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b></b> Causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                         |  |   |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>Hormez R. Guard</b>  |  |                         |  |   |  | TITLE (SPECIFY)<br><b>Assistant</b>  |  | DATE SIGNED<br><b>11/11/80</b>   |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Hormez R. Guard, M.D.</b>  |  |                         |  |   |  | ADDRESS<br><b>111 Penn Street, Balto., MD 21201</b>  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |                         |  | 23b. DATE<br><b>11/17/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Calvary Cem.</b>                                |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Anne Arundel Co. Md.</b>   |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Wm C March F/H</b>   |  |                         |  |   |  | ADDRESS<br><b>1101 E. North Avenue</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 19 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Rafael M. Brady</b>                             |  |

1102

RECEIVED 11-11-61

11-11-61

RECEIVED 11-11-61

11-11-61



1 - FOR  
STATE  
REGISTRAR

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>GENEVIEVE GENTRY HALL</b>   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>11/26/80</b>  |  | 2b. HOUR<br><b>4:15a<sub>M</sub></b>   |  |
| 3. SEX<br><b>FEMALE.</b>  |  | 4. RACE<br><b>BLACK.</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Dec. 17, 1906</b>  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS  |  | IF UNDER 1 YEAR MONTHS DAYS  |  | IF UNDER 24 HRS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Madison Co. Va.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>              |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.   |  | 10. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)<br><b>Retired</b>  |  | 11. KIND OF BUSINESS OR INDUSTRY<br><b>Seamstress</b>  |  |
| 12. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>12a. ST. <b>D.C.</b> 12b. COUNTY <b>D.C.</b> 12c. CITY OR TOWN <b>Washington</b>   |  | 13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13b. STREET ADDRESS<br><b>1130 Varnum St. N.E. Apt. 5</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Robert Gentry, Sr.</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Rosa Walker</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No.</b> 16b. SOCIAL SECURITY NO. <b>579-26-5539</b>   |  |
| 17. INFORMANT<br><b>Vittis Hall</b>   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b> 11/24/80 <sup>15</sup> <b>PM</b><br>4310<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>COMA</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <b>INTRACRANIAL BLEED</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 weeks</b><br><b>6 weeks</b> |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>ADULT ONSET DIABETES MELLITUS</b> |  |
| 19a. DATE OF OPERATION<br><b>10/10/80</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Acoustic Neuroma</b>  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>NONE</b>  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 2</b> , 19 <b>80</b> , to <b>Nov 26</b> , 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>Nov 23</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Michael T. Watkins</b>   |  | DEGREE<br><b>M.D.</b>  |  | 22c. DATE SIGNED<br><b>11/26/80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Michael T. Watkins M.D.</b>   |  | 22e. ADDRESS<br><b>JOHNS HOPKINS HOSPITAL</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>  |  | 23b. DATE<br><b>Nov. 30, 1980</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Locust Grove Bap. Ch. Radiant</b>   |  |
| 23d. LOCATION<br><b>Madison Va.</b>   |  | 24. FUNERAL DIRECTOR<br><b>Predky Funeral Home Box 321 Orange, Va.</b>   |  |  |  |

## MEDICAL CERTIFICATION

BP.



13

USA

D.C.

What Century 21

11

11

11

11

11

11

11

11

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 1 2 2

REG. NO.

FOR  
1 - STATE  
REGISTRAR

|   |  |   |  |  |                                |  |   |                               |   |                              |  |
|---|--|---|--|--|--------------------------------|--|---|-------------------------------|---|------------------------------|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>OTIS HALL JR.                         |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>November 29, 1980        |  | 2b. HOUR<br>M                  |  |   |                               |   |                              |  |
| 3 SEX<br>Male   |  | 4 RACE<br>Black   |  | 5 DATE OF BIRTH<br>3 MONTH 18 DAY 33 YEAR  |                                | 6 AGE (IN YEARS LAST BIRTHDAY)<br>47 YRS.                        |   | 7 UNDER 1 YEAR<br>MONTHS DAYS |   | 7 UNDER 24 HRS<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>S.C.                           |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.        |   |                               |   |                              |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>John Hopkins Hosp. |  |  |                                | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |   |                               | 12b. KIND OF BUSINESS OR INDUSTRY       |                              |  |
| 13a. STATE<br>MD  |  |   | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                               | 13e. STREET ADDRESS<br>827 Lynhurst St. |                              |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Otis Hall SR.                     |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anna Walker |  |                                |  |   |                               |   |                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>215-30-2177  |  | 17 INFORMANT<br>ADDRESS<br>Florine Hall 827 Lynhurst Street  |                                |  |   |                               |   |                              |  |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiopulmonary Arrest  
 4275  
 DUE TO, OR AS A CONSEQUENCE OF  
 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost  
 (b)  
 DUE TO, OR AS A CONSEQUENCE OF  
 (c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

## MEDICAL CERTIFICATION

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Darrell M. Gray M.D.</u>   |  |  |  | DEGREE<br>M.D.   |  | 22c. DATE SIGNED<br>12/1/80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Darrell M. Gray M.D.   |  |  |  | 22e. ADDRESS   |  |  |  |

|  |  |                      |  |   |  |  |  |
|--|--|----------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                     |  | 23b. DATE<br>12/5/80 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cheltenham VA Cem. Cheltenham |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>MD     |  |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br>Wm. C. March F/H 1101 E. North Ave. |  |                      |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 2 1980                         |  | 25b. REGISTRAR'S SIGNATURE<br><u>Darrell M. Gray</u> |  |

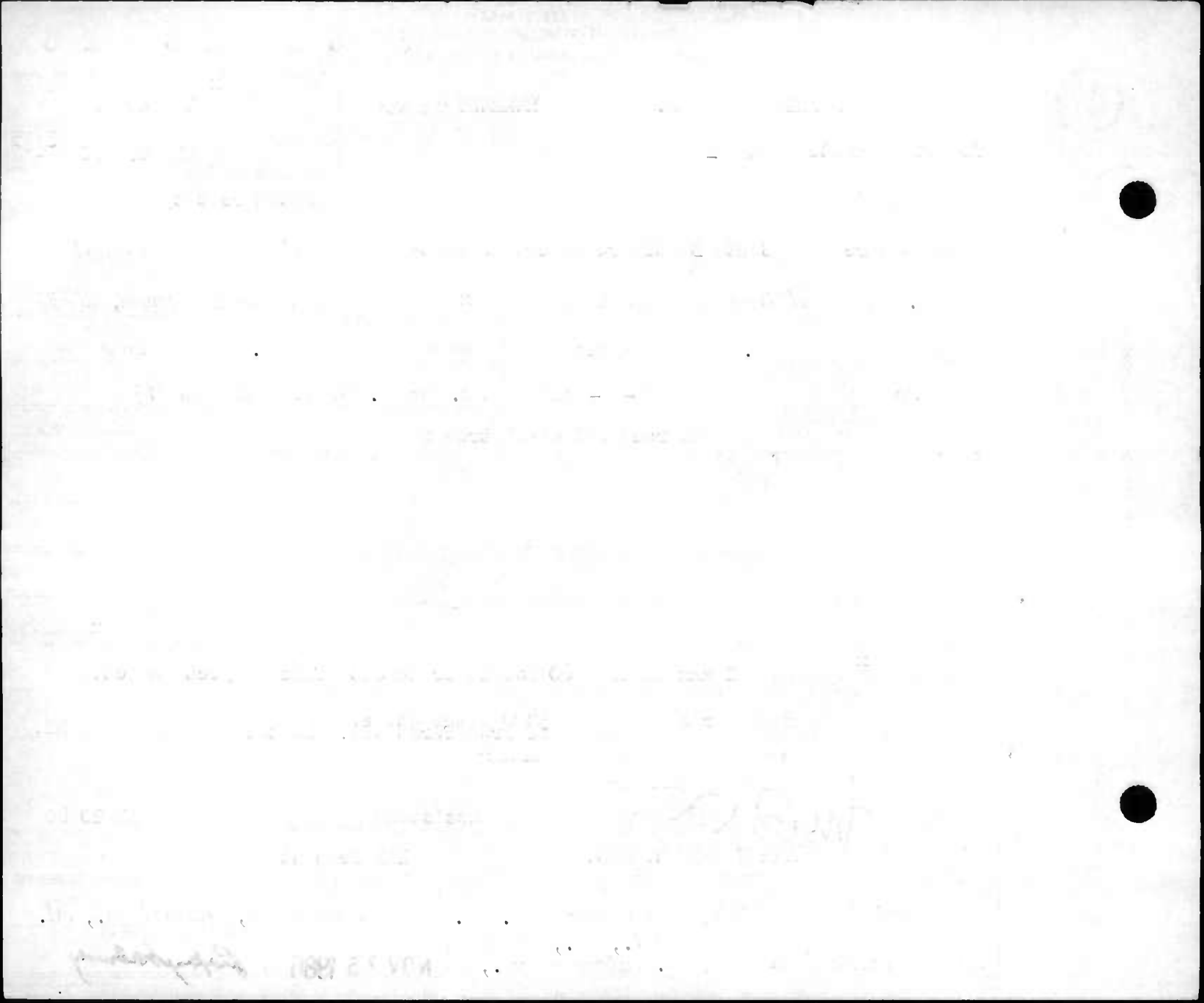
Handwritten signature or mark in the bottom left corner.

**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. **28123**

|  |  |  |  |
|--|--|--|--|
| FOR REGISTRAR  |  | 1- REGISTRAR   |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | 2a. DATE KNOWN OF DEATH  |  |
| BONNIE L. <del>BONNIE</del> Hamons   |  | DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR   |  |
| 3. SEX female  |  | 4. RACE white  |  |
| 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.   |  |
| 1-23-1962  |  | 18   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |
| Maryland   |  | USA  |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |
|  |  | Baltimore City   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION   |  |
| Baltimore  |  | South Baltimore General Hospital   |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| Student  |  | School   |  |
| 13a. STATE   |  | 13b. COUNTY  |  |
| Md.  |  | Baltimore  |  |
| 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| Baltimore  |  |  |  |
| 13e. STREET ADDRESS  |  | 14. FATHER'S NAME  |  |
| 3021 Mardel Avenue, 21230  |  | Guy E. Hamons  |  |
| 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |  |
| Norma L. Long  |  | no   |  |
| 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  |
| 215-90-6332  |  | Mr. Guy E. Hamons Same as #13  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |
| PART I DEATH WAS CAUSED BY: Thoraco-abdominal trauma   |  |  |  |
| IMMEDIATE CAUSE (a) _____  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF _____   |  |  |  |
| (b) _____  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF _____   |  |  |  |
| (c) _____  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |
|  |  |  |  |
| 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  |
|  |  | 2 xxx 11-20-80   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK |  |
| Passenger in auto/fixed object impact.   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |
|  |  | road   |  |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  | 21g. LOCATION CITY OR TOWN COUNTY STATE  |  |
| 8400 Potee St. e. of Frankfurst Ave. Balto. Md.  |  | Sykesville, Carroll Co., Md.   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |  |  |
| ACTUAL SIGNATURE <i>Ann M. Dixon</i>   |  | TITLE (SPECIFY) Assistant MEDICAL EXAMINER   |  |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.   |  | DATE SIGNED 11-20-80   |  |
| ADDRESS 111 Penn St.   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial   |  | 23b. DATE 11/24/1980   |  |
| 23c. NAME OF CEMETERY OR CREMATORY Lakeview Mem. Pk.   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |
|  |  | Sykesville, Carroll Co., Md.   |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR  |  |
| McCully Funeral Home 237 E. Patapsco Ave., Balt., Md., 21225   |  | NOV 25 1980  |  |
| 25b. REGISTRAR'S SIGNATURE <i>P. J. Kelly</i>  |  |  |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

35  
38  
35  
10  
2

1  
9  
1

BP

DHMH-16 25M  
(VRA 15, 4) 1/79



added info g551 1/16/81 gj

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

2 8 1 2 4

REG. NO.

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  | 2a. DATE OF DEATH  |  | 2b. HOUR  |  |
| 1 DECEASED NAME (TYPE OR PRINT)  |  | MONTH DAY YEAR   |  | MONTHS DAYS HOURS MIN   |  |
| FIRST MIDDLE LAST  |  | 11 19 80   |  | 11:58 AM  |  |
| 3 SEX  |  | 4 RACE   |  | 5 DATE OF BIRTH   |  |
| Female   |  | White  |  | MONTH DAY YEAR  |  |
|  |  |  |  | 12 06 14  |  |
| 6a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| Maryland   |  | USA  |  |   |  |
| 10 CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 9 BALTIMORE CITY OR COUNTY OF DEATH   |  |
| Baltimore  |  | University of Maryland Hospital  |  | Baltimore City MD.  |  |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13a. INSIDE CITY LIMITS?   |  | 13b. STREET ADDRESS   |  |
| 13a STATE  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                    |  | P.O. Box 447  |  |
| Maryland   |  |  |  |   |  |
| 14 FATHER'S NAME   |  | 15 MOTHER'S MAIDEN NAME  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |  |
| William Arthur Hoffman   |  | Tiedemann Hoffman  |  | 16b. SOCIAL SECURITY NO.  |  |
|  |  |  |  | 220-32-2962   |  |
|  |  |  |  | 17 INFORMANT  |  |
|  |  |  |  | Robert Hampson, Jr.   |  |
|  |  |  |  | ADDRESS 11502 Taneytown Pike Md. 21727  |  |
|  |  |  |  | 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis                         |  |
|  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks  |  |
|  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF (b) urinary tract infection 4 weeks  |  |
|  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF (c) chronic diabetic renal failure years   |  |
|  |  |  |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) diabetes mellitus   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   |  |
|  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |
|  |  | P.M. 19  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |
|  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from November 6, 1980 to November 19, 1980, that (I) (we) last saw the deceased alive on November 19, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (d-d) did not view the body after death. |  | 22b. SIGNATURE   |  | 22c. DATE SIGNED  |  |
|  |  | O. Rivas MD  |  | 4/19/80   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |   |  |
| O. Rivas MD  |  | UMH Balto., Md   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |
| Burial   |  | Nov. 24, 1980  |  | London Park Cemetery  |  |
| 24. FUNERAL DIRECTOR NAME  |  | 24b. ADDRESS   |  | 24c. CITY OR TOWN   |  |
| John M. Skales   |  | Emmitsburg Md.   |  | Baltimore, Maryland   |  |

in 1891, 1892, 1893, 1894, 1895, 1896, 1897, 1898, 1899, 1900, 1901, 1902, 1903, 1904, 1905, 1906, 1907, 1908, 1909, 1910, 1911, 1912, 1913, 1914, 1915, 1916, 1917, 1918, 1919, 1920, 1921, 1922, 1923, 1924, 1925, 1926, 1927, 1928, 1929, 1930, 1931, 1932, 1933, 1934, 1935, 1936, 1937, 1938, 1939, 1940, 1941, 1942, 1943, 1944, 1945, 1946, 1947, 1948, 1949, 1950, 1951, 1952, 1953, 1954, 1955, 1956, 1957, 1958, 1959, 1960, 1961, 1962, 1963, 1964, 1965, 1966, 1967, 1968, 1969, 1970, 1971, 1972, 1973, 1974, 1975, 1976, 1977, 1978, 1979, 1980, 1981, 1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572,

22

100

100-443887-1000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8028125

REG. NO.

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | 2a. DATE OF DEATH  |  | 2b. HOUR  |  |
|   |  | OKA Hampton  |  | 11 10 80   |  | 2 PM  |  |
| 3 SEX<br>Female   |  | 4 RACE<br>Black  |  | 5 DATE OF BIRTH<br>11 27 94  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>85 YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Lafayette Square Nursing Center |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 14 FATHER'S NAME<br>Henry HANDY   |  | 15. MOTHER'S MAIDEN NAME<br>Cornelius Wooden   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 17 SOCIAL SECURITY NO<br>578 346262   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>3398 IMMEDIATE CAUSE (a) Abdominal mass.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Anorexia, depression, Dehydration<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) poor nutrition, Cardiac Arrest        |  | 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  | 22c. DATE SIGNED<br>11/11/80  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/29 1980 to 11/10 1980, that (I) (we) lost saw the deceased alive on 11/10 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE<br>Laurent Pierre Philippe  |  | 22e. ADDRESS<br>238 N Carey St Baltimore Md 21223  |  | 22c. DATE SIGNED<br>11/11/80  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>Nov. 15, 1980   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Harmony Memorial Park  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Landover, Maryland  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Stewart Funeral Home   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 14 1980   |  | 25b. REGISTRAR'S SIGNATURE<br>Richard K. ...   |  |   |  |

24  
 96 11 10 80 96  
 48 11 27 94 84  
 Maryland, Nis  
 Baltimore, City  
 Baltimore, Baltimore  
 140 N. Lafayette Ave

278 340324

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 1 2 6

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |  |   |                                   |   |  |  |  |
|--|--|--|--|---|--|---|-----------------------------------|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><i>Murrell Handy</i>  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>Nov 7, 1980</i> |   | 2b. HOUR<br><i>9:05 PM</i>                                       |   |                                   |   |  |  |  |
| 3. SEX<br><i>male</i>  |  | 4. RACE<br><i>Black</i>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>5 14 04</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS<br><i>76</i>     |                                   |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>MD</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD. |                                   |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Balto.</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Greater Penna. Ave. N.H.</i> |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |   | 12b. KIND OF BUSINESS OR INDUSTRY |   |  |  |  |
| 13a. STATE<br><i>Md.</i>   |  |  |  | 13b. COUNTY<br><i>Balto.</i>  |  | 13c. CITY OR TOWN<br><i>Balto.</i>                                |                                   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><i>3305 Howard Park Ave.</i>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>Unkn</i>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Unkn</i>   |  |   |                                   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <i>No</i>   |  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES) <i>214-12-4910</i>  |  | 17. INFORMANT ADDRESS<br><i>Mrs. Decker-Admin. G.P.N.H.</i>       |                                   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Carcinoma of prostate &amp; secondaries</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>1850</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>32 1/2</i> |  |  |  |   |  |   |                                   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>32 1/2</i>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:<br><i>COPD, Hypertension, decubitus ulcers</i>  |  |  |  |   |  |   |                                   |   |  |  |  |
| 19a. DATE OF OPERATION<br><i>9-9</i>   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |                                   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><i>19</i>   |  |   |                                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |   |                                   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>2-18-</i> 19 <i>76</i> , to <i>11-7-</i> 19 <i>80</i> , that (I) (we) lost saw the deceased alive on <i>11-7-</i> 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                    |  |  |  |   |  |   |                                   |   |  |  |  |
| 22b. SIGNATURE<br><i>Syllan</i>  |  |  |  | DEGREE<br><i>MD</i>   |  |   |                                   | 22c. DATE SIGNED<br><i>11-8-80</i>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>SHAIKAT Y. KHAN</i>  |  |  |  | 22e. ADDRESS<br><i>223 Eastern Ave; Balto, MD 21221</i>   |  |   |                                   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>   |  |  |  | 23b. DATE<br><i>11/14/80</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Mt. Calvary Cem.</i>     |                                   |   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><i>Anne Arundel Co., Md.</i>  |  |
| 24. FUNERAL DIRECTOR NAME<br><i>Wm C. March F/H</i>  |  |  |  |   |  | ADDRESS<br><i>1101 E. North Ave.</i>                              |                                   | 25a. DATE REC'D. BY REGISTRAR<br><i>NOV 12 1980</i>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Patricia K. Brady</i>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

I, the undersigned, do hereby certify that  
 the within and foregoing is a true and correct  
 copy of the original as the same appears  
 in the records of the County of \_\_\_\_\_  
 State of Texas, this \_\_\_\_\_ day of \_\_\_\_\_  
 19\_\_\_\_.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |   |   |  |   |  |
|---|--|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>NAOMA RUTH HANNA  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>NOVEMBER 22 80 |   |  | 2b. HOUR<br>2:00P <sub>M</sub>  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Dec. 23, 1930   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>49 YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST AGNES HOSPITAL |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Home Maker  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>-  |  |
| 13a. STATE<br>Maryland  |  | 13b. CITY OR TOWN<br>Balto.  |   | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13d. STREET ADDRESS<br>9206 Bengal Rd.<br>Randallstown, Md. 21133   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Albert L. Ritter  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ruth N. Clarke  |   | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>no   |  |   |  |
| 16a. SOCIAL SECURITY NO.<br>216-28-0948   |  | 17. INFORMANT<br>Mr. Robert Hanna<br>9206 Bengal Rd. Randallstown, Md. 21133   |   |   |  |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) MULTIFOCAL SEPTAL MYOCARDIAL INFARCTION<br>2500<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) SEGMENTAL CORONARY ATHEROSCLEROSIS<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) DIABETES MELLITUS<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |   |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>NEPHROSCLEROSIS  |  |  |   |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.   |  |  |   |   |  |   |  |
| 22b. SIGNATURE<br>Michael E. Pelczar  |  |  |   | DEGREE<br>MD  |  | 22c. DATE SIGNED<br>11/23/80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MICHAEL E. PELCZAR M.D.  |  |  |   | 22e. ADDRESS<br>900 CATON AVE BALTIMORE MD 21229  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>11-25-80  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Lake View   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Eldersburg Carroll Md.  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Loring Byers Funeral Directors P.A.<br>8728 Liberty Rd. Randallstown, Md. 21133   |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 25 1980  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |  |

BP

NOVEMBER 1964

AMMAN

STATE

UNITED STATES

OFFICE OF THE ATTORNEY GENERAL



**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

8 0 2 8 1 2 8

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |   |   |  |
|---|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FLORENCE K. HANSEN   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 15 80   |   | 2b. HOUR<br>12 08 P.M.   |
| 3. SEX<br>F   | 4. RACE<br>C  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2-16-1906   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>City MD.  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Balt Md.   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Univ. of Md Hosp |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Thurswife                   | 12b. KIND OF BUSINESS OR INDUSTRY<br>at home  |  |
| 13a. STATE<br>md  | 13b. COUNTY<br>BALT   | 13c. CITY OR TOWN<br>Balt   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>1105 S. CAREY ST. 21223  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William F. Bennett  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Cauline Rockett  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212-30 1414 B  |   | 17. INFORMANT<br>ADDRESS<br>Don M. Jones 1105 S. Carey St. 21223                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u><br><u>4275</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>&lt; 1 hour</u> |   |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>History of CHF &amp; Diabetes mellitus</u>  |   |   |   |   |  |
| 19a. DATE OF OPERATION<br><u>Nov 15 1980</u>  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>CHF</u>  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |   |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. _____ 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br>_____ |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>_____   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>_____                              |  |
| 22a. I certify that (this hospital) attended the deceased from <u>NOVEMBER 15, 1980</u> , to <u>Nov 15, 1980</u> , that (we) last saw the deceased alive on <u>Nov 15, 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.   |   |   |   |   |  |
| 22b. SIGNATURE<br><u>Joseph A. Petrozzu MD</u>  |   | DEGREE<br>MAO   |   | 22c. DATE SIGNED<br>11/15/80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Joseph A. Petrozzu</u>  |   | 22e. ADDRESS<br><u>University Hospital<br/>22 S. Greene St. Balt Md.</u>  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>Burial</u>   |   | 23b. DATE<br><u>11-19-1980</u>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Lorraine Ch. Cemetery - Woodlawn</u>           |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Balt Md. 2nd</u>   |   |   |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Shirley Thomas</u>   |   | ADDRESS<br><u>Balt Md. 21223</u>  |   | 25a. DATE REC'D. BY REGISTRAR<br><u>NOV 20 1980</u>                                     |  |
|   |   |   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Ray McBrady</u>  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED  
JAN 10 1970

157  
158  
159

160  
161  
162  
163  
164  
165  
166  
167  
168  
169  
170  
171  
172  
173  
174  
175  
176  
177  
178  
179  
180  
181  
182  
183  
184  
185  
186  
187  
188  
189  
190  
191  
192  
193  
194  
195  
196  
197  
198  
199  
200

201  
202  
203  
204  
205  
206  
207  
208  
209  
210  
211  
212  
213  
214  
215  
216  
217  
218  
219  
220  
221  
222  
223  
224  
225  
226  
227  
228  
229  
230  
231  
232  
233  
234  
235  
236  
237  
238  
239  
240  
241  
242  
243  
244  
245  
246  
247  
248  
249  
250



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |   |   |                                      |  |  |  | 8 0  | 2 8 | 1 2  | 9 |   |   |  |                     |  |
|---|--|---|--|---|---|--------------------------------------|--|--|--|--|-----|--|---|---|---|--|---------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  |   |  |   | CERTIFICATE OF DEATH                                    |                                      |  |  |  | REG. NO.   |     |  |   |   |   |  |                     |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   |  |   | FIRST MIDDLE LAST                                       |                                      |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR                               |     |  |   | 2b. HOUR  |   |  |                     |  |
| ARTHUR  |  |   |  |   | HARBOTTLE Jr.   |                                      |  |  |  | 11 8 80  |     |  |   | 8:55 A.M.                                       |   |  |                     |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |   | 6. AGE (IN YEARS LAST BIRTHDAY)      |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS.   |     |  |   |   |   |  |                     |  |
| MALE  |  | WHITE   |  | 2 10 17   |   | 63 YRS.                              |  | MONTHS   |  | DAYS   |     | HOURS  |   | MIN.  |   |  |                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |  |  |  |     |  |   |   |   |  |                     |  |
| Virginia  |  | U.S.A.  |  |   |   | BALTIMORE CITY MD.                   |  |  |  |  |     |  |   |   |   |  |                     |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |   |                                      |  |  |  |  |     | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |   | 12b. KIND OF BUSINESS OR INDUSTRY               |   |  |                     |  |
| BALTIMORE   |  | ST AGNES HOSPITAL   |  |   |   |                                      |  |  |  |  |     | Mechanic   |   | Printing  |   |  |                     |  |
| 13a. STATE  |  |   |  |   | 13b. COUNTY   |                                      |  |  |  | 13c. CITY OR TOWN  |     |  |   |   | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS |  |
| Md.   |  |   |  |   |   |                                      |  |  |  | Baltimore  |     |  |   |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 21229               |  |
| 14. FATHER'S NAME   |  |   |  |   | 15. MOTHER'S MAIDEN NAME                                |                                      |  |  |  |  |     |  |   |   |   |  |                     |  |
| FIRST MIDDLE LAST   |  |   |  |   | FIRST MIDDLE LAST                                       |                                      |  |  |  |  |     |  |   |   |   |  |                     |  |
| Arthur Harbottle  |  |   |  |   | Lotta Falwell   |                                      |  |  |  |  |     |  |   |   |   |  |                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |   |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES) |                                      |  |  |  | 17. INFORMANT ADDRESS  |     |  |   |   |   |  |                     |  |
| No  |  |   |  |   | 577-05-9054   |                                      |  |  |  | A. Evan Harbottle  |     |  |   |   | Orange County   |  | Los Angeles, Ca.    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:  |  |   |  |   |   |                                      |  |  |  |  |     |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |   |  |                     |  |
| 5715 IMMEDIATE CAUSE (a) Cirrhosis of liver. congestive heart failure. 6 days.  |  |   |  |   |   |                                      |  |  |  |  |     |  |   |   |   |  |                     |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |   |   |                                      |  |  |  |  |     |  |   |   |   |  |                     |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |   |  |   |   |                                      |  |  |  |  |     |  |   |   |   |  |                     |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |   |   |                                      |  |  |  |  |     |  |   |   |   |  |                     |  |
| (c)   |  |   |  |   |   |                                      |  |  |  |  |     |  |   |   |   |  |                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |   |                                      |  |  |  |  |     |  |   |   |   |  |                     |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |                                      |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |     |  |   |   |   |  |                     |  |
|   |  |   |  |   |   |                                      |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |     |  |   |   |   |  |                     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR   |   |                                      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2) |  |  |     |  |   |   |   |  |                     |  |
|   |  |   |  | P.M. 19   |   |                                      |  |  |  |  |     |  |   |   |   |  |                     |  |
| 21d. INJURY OCCURRED  |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   |                                      |  | 21f. LOCATION  |  |  |     |  |   |   |   |  |                     |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   |  |   |   |                                      |  | CITY OR TOWN COUNTY STATE  |  |  |     |  |   |   |   |  |                     |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |   |                                      |  |  |  |  |     |  |   |   |   |  |                     |  |
| 22b. SIGNATURE  |  |   |  |   |   |                                      |  |  |  | DEGREE   |     | 22c. DATE SIGNED   |   |   |   |  |                     |  |
| Mathew  |  |   |  |   |   |                                      |  |  |  |  |     |  |   |   |   |  |                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |  |   |   |                                      |  |  |  | 22e. ADDRESS   |     |  |   |   |   |  |                     |  |
| A. Mathew   |  |   |  |   |   |                                      |  |  |  | St. Agnes Hospital. Baltimore.                                 |     |  |   |   |   |  |                     |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  |   |  | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  | 23d. LOCATION  |     |  |   |   |   |  |                     |  |
| Cremation   |  |   |  | 11/14/1980  |   | Westview Mem. Pk.                    |  |  |  | Westview, Balto. Co., Md.                                      |     |  |   |   |   |  |                     |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS  |  |   |  |   |   |                                      |  |  |  | 25a. DATE REC'D. BY REGISTRAR                                  |     | 25b. REGISTRAR'S SIGNATURE                                       |   |   |   |  |                     |  |
| G. Truman Schwab 3512 Frederick Ave.  |  |   |  |   |   |                                      |  |  |  | 21229 NOV 19 1980  |     | [Signature]  |   |   |   |  |                     |  |



AT THE HOSPITAL

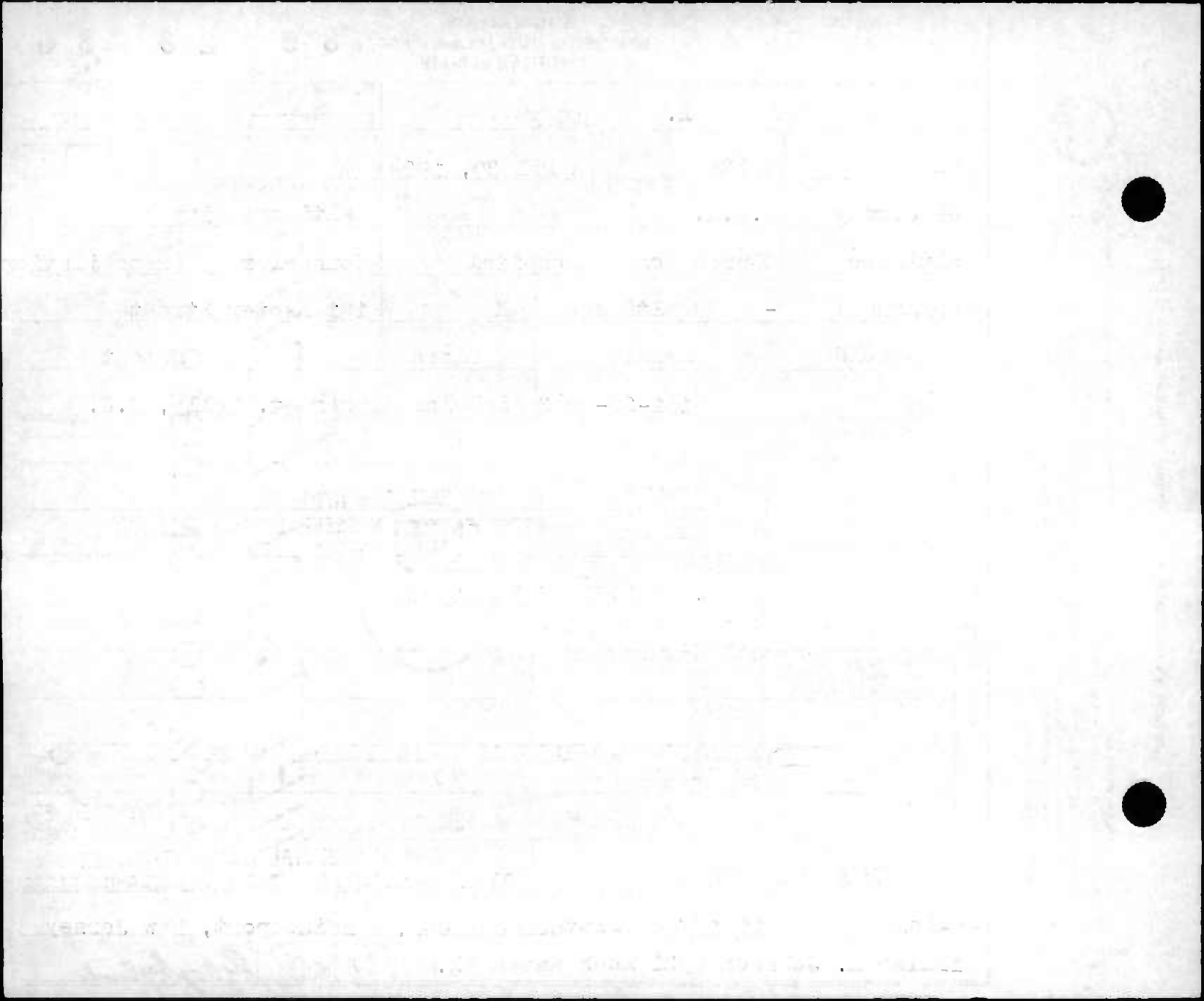
177-10-0000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |  | REG. NO. 8028130                             |  |
|---|--|--|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |   |  |   |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>HAROLD L. HARKER</b>   |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 23 1980</b>  |  | 2b. HOUR<br><b>2:05A.M.</b>  |  |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>April 29, 1924</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>56</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New Jersey</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Church Home &amp; Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Counselor</b>                        |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Rehabilitation</b>   |  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>-</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                        |  | 13e. STREET ADDRESS<br><b>101 Exeter Street</b>  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Harold Harker</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Clara Dumont</b>  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>151-20-8042</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Nicholas Harker Mt. Holly, N.J.</b>  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br><b>2866</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>PULMONARY AND RENAL FAILURE; HYPERKALEMIA</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>DISSEMINATED MASSIVE INTRAABDOMINAL BLEEDING SECONDARY TO DISSEMINATED INTRAVESICULAR COAGULATION WITH CARDIAC ARREST</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 19a. DATE OF OPERATION<br><b>NOVEMBER 13, 1980</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>INTRA-ABDOMINAL BLEEDING</b>  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 19c. DATE OF OPERATION<br><b>NOVEMBER 16, 1980</b>  |  | 19d. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>INCISIONAL HERNIA</b>   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                              |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>P.M. 19</b>   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>CHURCH HOSPITAL CORPORATION, XX</b>   |  |   |  |  |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>NOVEMBER 11, 1980</b> to <b>NOVEMBER 23, 1980</b> , that (I) (we) last saw the deceased alive on <b>NOVEMBER 23, 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |  |  |  |  |
| 27b. SIGNATURE<br><b>Sompalli Prasad</b>  |  |  |  |   |  | DEGREE<br><b>MD</b>   |  | 27c. DATE SIGNED<br><b>NOVEMBER 23, 1980</b>   |  |  |  |
| 27d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SOMPALLI PRASAD, MD.</b>  |  |  |  |   |  | 27e. ADDRESS<br><b>CHURCH HOSPITAL CORPORATION, XX</b><br><b>100 N. BROADWAY, BALTIMORE, MARYLAND 21231</b> |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11/26/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Brotherhood Cem.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Hainesport, New Jersey</b>                                 |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>William E. Johnson 8521 Loch Raven Bl.</b>   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 26 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |  |  |   |  | REG. NO. 80 28131   |  |                              |  |
|--|--|---|--|--|--|--|--|---|--|---|--|------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>BERNARD</b> <b>Leo</b> <b>HARKINS</b>   |  |   |  |  |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>20</b> YEAR <b>80</b> |  | 2b. HOUR<br><b>2:20 P.M.</b> |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>7</b> DAY <b>24</b> YEAR <b>20</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>60</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>  |  | IF UNDER 24 HRS<br>HOURS <b></b> MIN. <b></b>                     |  |                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Penna</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |   |  |   |  |                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore City Hospitals</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Civil Servant</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Fed. Gov't.</b>   |  |   |  |                              |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Balto.</b>  |  | 13c. CITY OR TOWN<br><b>Dundalk</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>8134 Midhaven Rd. 21222</b>   |  |   |  |                              |  |
| 14. FATHER'S NAME<br>FIRST <b>Bernard</b> MIDDLE <b></b> LAST <b>Harkins</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Victoria</b> MIDDLE <b></b> LAST <b>Unknown</b>   |  |  |  |   |  |   |  |                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>WW 11</b>  |  | 17. INFORMANT<br><b>John Firestone</b> ADDRESS <b>190 E. Olmstead Dr. Titusville, Fla. 32780</b>   |  |  |  |   |  |   |  |                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>5700 IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST</b>  |  |   |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                      |  |                              |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |   |  |  |  |  |  |   |  | (b) <b>ACUTE HEPATIC FAILURE</b> <b>1 month</b>                   |  |                              |  |
|  |  |   |  |  |  |  |  |   |  | (c) <b>ACUTE RENAL FAILURE</b> <b>2 wks.</b>                      |  |                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |  |  |  |  |   |  |   |  |                              |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |  |   |  |                              |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |   |  |                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/20</b> , 19 <b>80</b> , to <b>11/20</b> , 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>11/20</b> , 19 <b>80</b> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. |  |   |  |  |  |  |  |   |  |   |  |                              |  |
| 22b. SIGNATURE<br><b>Peter Stamas MD</b> DEGREE  |  |   |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11/20/80</b>   |  |   |  |                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PETER STAMAS MD</b>  |  |   |  |  |  | 22e. ADDRESS<br><b>BALTIMORE HOSP</b>  |  |   |  |   |  |                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>11/26/1980</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount Crematory</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |  |   |  |   |  |                              |  |
| 24. FUNERAL DIRECTOR<br><b>Walter Brooks Bradley Inc. Dundalk Md. 21222</b>  |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 28 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Peter Stamas</b>   |  |   |  |                              |  |



NOV 8 1966

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

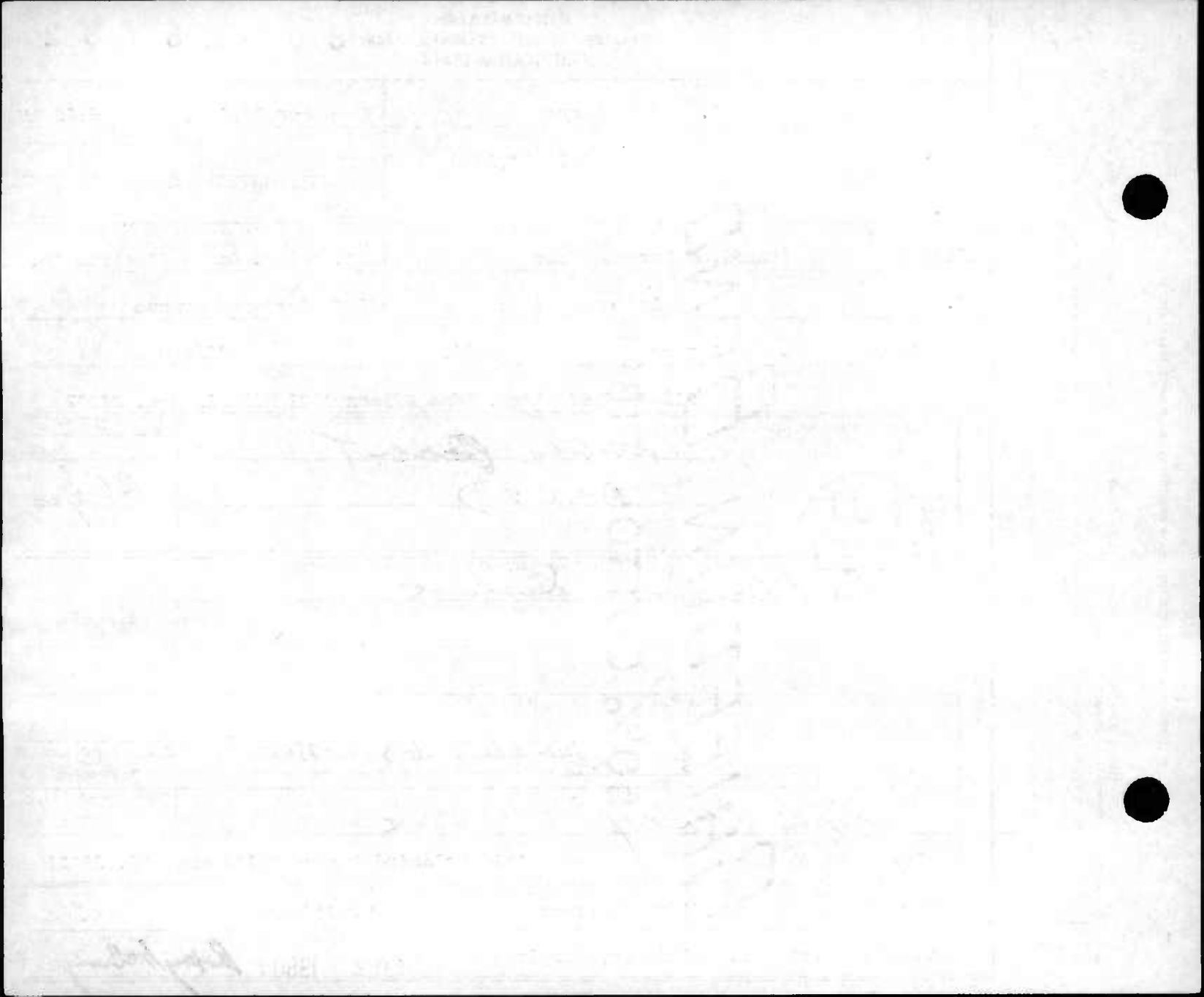
2 8 1 3 2

REG. NO.

|  |  |  |  |  |                     |  |
|--|--|--|--|--|---------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>James G. Harper   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 30, 1980 |  | 2b. HOUR<br>6:10 AM |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>July 24, 1900  |                     |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>80 YRS.   |  | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.  |  | 8. CITIZEN OF WHAT COUNTRY?<br>USA   |                     |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>city MD.   |  | 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Hamilton Nursing Home |                     |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Ret. Balto. Gas & Electric Co.   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |                     |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.  |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Baltimore   |                     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>James B. Harper  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Belle Billings  |  |  |                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no   |  | 16b. SOCIAL SECURITY NO.<br>212-05-6284  |  | 17. INFORMANT ADDRESS<br>Mrs. Edna Wilson 1901 Wilhelm Ave. 21237  |                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u><br>4292 DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ASCVD</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>20 yrs |  |  |  |  |                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>Parkinson's Disease</u>   |  |  |  |  |                     |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                     |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |                     |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |                     |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  | 22a. I certify that (I) (this hospital) attended the deceased from <u>March</u> 19 <u>63</u> to <u>Nov-30</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>11-5</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. |  |  |                     |  |
| 22b. SIGNATURE<br><u>Dr. Wyman K. Wong</u>   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  | 22c. DATE SIGNED   |                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Wyman K. Wong MD  |  | 22e. ADDRESS<br>6730 Holabird Avenue Baltimore, Md. 21221  |  |  |                     |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>Cremation   |  | 23b. DATE<br>Dec. 2, 1980  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Greenmount   |                     |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md.  |  | 24. FUNERAL DIRECTOR<br>NAME<br>Leonard J. Ruck Inc. Baltimore, Maryland   |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 2 1980  |                     |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>History McCreedy</u>  |  |  |  |  |                     |  |

MEDICAL CERTIFICATION

BP





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  | 20. DATE KNOWN OF DEATH   |  | 21. DATE KNOWN OF DEATH   |  | 22. DATE KNOWN OF DEATH   |  | 23. DATE KNOWN OF DEATH   |  | 24. DATE KNOWN OF DEATH   |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | 2. DATE KNOWN OF DEATH  |  | 3. DATE KNOWN OF DEATH  |  | 4. DATE KNOWN OF DEATH  |  | 5. DATE KNOWN OF DEATH  |  | 6. DATE KNOWN OF DEATH  |  |
| Annie Harris  |  | 11 22 80  |  | 11 22 80  |  | 11 22 80  |  | 11 22 80  |  | 11 22 80  |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS)   |  | 7. IF UNDER 1 YR.   |  | 8. IF UNDER 24 HRS.   |  |
| Female  |  | Black   |  | 6/4/1980  |  | 100 YRS.  |  | MONTHS  |  | DAYS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                      |  | 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION                  |  |
| Virginia  |  | USA   |  | WIDOWED   |  | Baltimore City, MD.   |  | Baltimore   |  | 1745 Cliftview Avenue   |  |
| 12a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                     |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  | 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  |
| Housewife   |  | ****  |  | Maryland  |  |   |  | Baltimore,  |  | YES   |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?                              |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |  | 17b. ADDRESS  |  |
| Squire West   |  | Fannie Booker   |  | No  |  | Not Obtained  |  | Mr. Frank Hairr   |  | Dillwyn, Va. 23936  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  | 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                         |  | 20. AUTOPSY?  |  | 21a. EXTERNAL CAUSE WAS   |  | 21b. TIME OF INJURY   |  |
| PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease   |  |   |  |   |  | YES   |  | UNDERLYING  |  | HOUR A.M. MONTH DAY YEAR  |  |
| 4292  |  |   |  |   |  | NO  |  | OR CONTRIBUTING CAUSE OF DEATH  |  | P.M. 19   |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.                                       |  |   |  |   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |  | 21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)               |  |
|   |  |   |  |   |  |   |  |   |  | 21e. LOCATION   |  |
|   |  |   |  |   |  |   |  |   |  | CITY OR TOWN  |  |
|   |  |   |  |   |  |   |  |   |  | COUNTY  |  |
|   |  |   |  |   |  |   |  |   |  | STATE   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). |  | 22a. I certify that I took charge of the remains described above, held an |  | 22b. I certify that I took charge of the remains described above, held an |  | 22c. I certify that I took charge of the remains described above, held an |  | 22d. I certify that I took charge of the remains described above, held an     |  | 22e. I certify that I took charge of the remains described above, held an |  |
|   |  | Autopsy   |  | Inspection  |  | Inquiry   |  | and in my opinion   |  | death resulted from:  |  |
|   |  | [ ]   |  | [X]   |  | [ ]   |  | [ ]   |  | Natural causes  |  |
|   |  | [ ]   |  | [ ]   |  | [ ]   |  | [ ]   |  | Accident  |  |
|   |  | [ ]   |  | [ ]   |  | [ ]   |  | [ ]   |  | Suicide   |  |
|   |  | [ ]   |  | [ ]   |  | [ ]   |  | [ ]   |  | Homicide  |  |
|   |  | [ ]   |  | [ ]   |  | [ ]   |  | [ ]   |  | Undetermined manner   |  |
| ACTUAL SIGNATURE  |  | TITLE (SPECIFY)   |  | DATE SIGNED   |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                 |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |
| Virginia L. Dolan   |  | Assistant   |  | 11/22/80  |  | Burial  |  | 11/26/80  |  | Family Cemetery   |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |  | ADDRESS   |  | 23d. LOCATION (CITY OR TOWN)  |  | 23e. DATE REC'D. BY REGISTRAR   |  | 23f. REGISTRAR'S SIGNATURE  |  | 23g. DATE REC'D. BY REGISTRAR   |  |
| Virginia L. Dolan, M.D.   |  | 111 Penn Street   |  | Buckingham Co., Va.   |  | DEC 2 1980  |  | [Signature]   |  | DEC 2 1980  |  |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  | 25c. DATE REC'D. BY REGISTRAR   |  | 25d. REGISTRAR'S SIGNATURE  |  | 25e. DATE REC'D. BY REGISTRAR   |  |
| Bland-Reid Funeral Home Farmville, Va. 23901  |  | DEC 2 1980  |  | [Signature]   |  | DEC 2 1980  |  | [Signature]   |  | DEC 2 1980  |  |

1945

X

1946

X

1947

1948

1949

X

1950

X

X

X

X

X

X

X

X

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

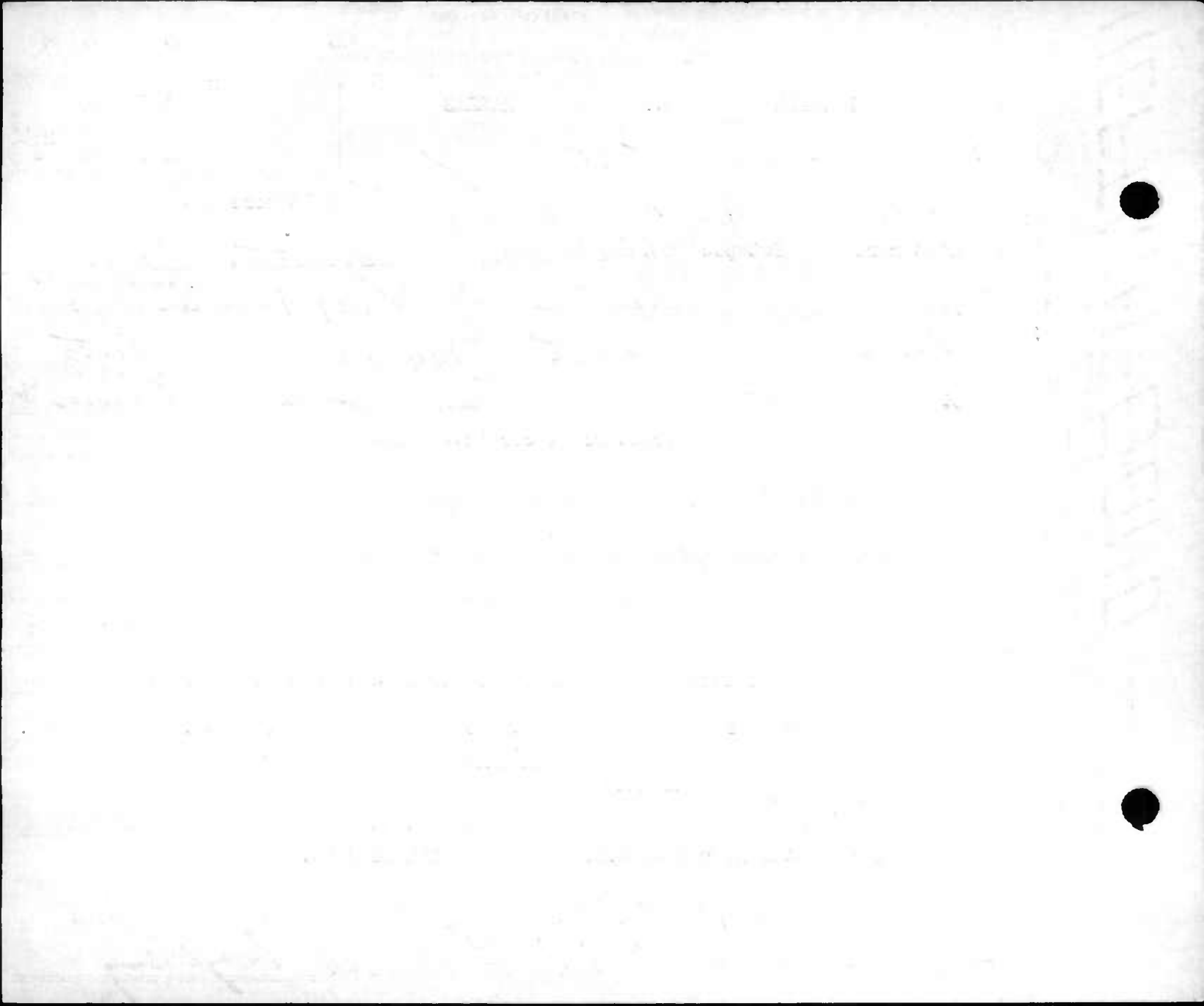
DHMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

|  |                         |   |  |   |   |   |  |   |
|--|-------------------------|---|--|---|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>BEVERLY A. HARRIS</b>   |                         |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>11 8 1980</b> |   |   | 2b. HOUR <b>2:40 a</b>  |  |   |
| 3. SEX<br><b>female</b>  | 4. RACE<br><b>white</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>2-24-1945</b>   | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) <b>35</b> YRS.  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | IF UNDER 24 HRS.  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>11 8 1980</b>                                     |  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Ind.</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>                                   |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Patapsco &amp; Annapolis Rd.</b> |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Secretary</b>               |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Soda Co.</b>  |
| 13a. STATE<br><b>Ind.</b>  |                         | 13b. COUNTY<br><b>Balto.</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>604 Fifth Ave.</b>  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Louis Haupt</b>   |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mildred Laetz</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>NO</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>-</b>  |  | 16c. ADDRESS<br><b>Frank H. Smith 308 Woodgreen St. 21223</b>   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY: <b>Fracture of cervical spine</b>   |                         |   |  |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| IMMEDIATE CAUSE (a) <b>8121</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |                         |   |  |   |   |   |  |   |
| DUE TO, OR AS A CONSEQUENCE OF (b)   |                         |   |  |   |   |   |  |   |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |                         |   |  |   |   |   |  |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                         |   |  |   |   |   |  |   |
| 19a. DATE OF OPERATION   |                         |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |   |   |  | 20. AUTOPSY?<br><b>HEAD ONLY</b><br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>2:20 PM 11 -8- 1980</b>                            |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Passenger in auto/auto collision.</b> |   |  |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |                         |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>road</b>                               |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>Patapsco &amp; Annapolis Rd., Balto. Md.</b>                      |   |  |   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |   |  |   |   |   |  |   |
| ACTUAL SIGNATURE<br><b>Ann M. Dixon, M.D.</b>  |                         |   | TITLE (SPECIFY)<br><b>Assistant</b>  |   |   | DATE SIGNED<br><b>11-8-80</b>   |  |   |
| EXAMINER'S NAME (TYPE OR PRINT)  |                         |   | ADDRESS<br><b>111 Penn St.</b>   |   |   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>burial</b>   |                         | 23b. DATE<br><b>11-11-1980</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ind. National Mem. Pk.</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Laurel Ind.</b>                                |  |   |
| FUNERAL DIRECTOR<br><b>John P. Cowan &amp; Son Inc.</b>  |                         | ADDRESS<br><b>Balto. Ind. 21223</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 12 1980</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Antony McCreary</b>  |  |   |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. EXECUTE THE CERTIFICATE, WRITING TO THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  | REG. NO. 28135  |  |
|---|--|--|--|--|--|--|--|--|--|---|--|
| 1. FOR REGISTRAR  |  |  |  |  |  |  |  |  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Charles G. Harris</b>   |  |  |  |  |  |  |  |  |  | 2b. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>11 1 1980</b> |  |
| 2. SEX RACE<br><b>Male White</b>  |  |  |  |  |  |  |  |  |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>11 2 1980</b>  |  |
| 3. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4/2/06</b>   |  |  |  |  |  |  |  |  |  | 2d. HOUR<br><b>3:00 P.M.</b>  |  |
| 4. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>74 YRS.</b>  |  |  |  |  |  |  |  |  |  |   |  |
| 5. IF UNDER 1 YR. IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN.  |  |  |  |  |  |  |  |  |  |   |  |
| 6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |  |  |  |  |  |  |  |  |  | 7. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>   |  |
| 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  |  |  |  |  |  |  |  |   |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>   |  |
| 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>7111 Commercial Avenue</b>   |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Plumber</b>                             |  |
| 13a. STATE<br><b>Md.</b>  |  |  |  |  |  |  |  |  |  | 13b. COUNTY<br><b>Balto.</b>  |  |
| 13c. CITY OR TOWN<br><b>Balto.</b>  |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |  |
| 13e. STREET ADDRESS<br><b>4014 Echodale Ave.</b>  |  |  |  |  |  |  |  |  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James E. Harris</b>  |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary L. Patterson</b>                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>no</b>  |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>212-16-3381</b>  |  |
| 17. INFORMANT<br><b>Eva Harris (wife)</b>   |  |  |  |  |  |  |  |  |  | ADDRESS<br><b>same address</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>4292</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |
| 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  |   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |  |  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |  |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE <u>Margarita A. Korell</u> M.D. TITLE (SPECIFY) <b>Assistant</b> MEDICAL EXAMINER  |  |  |  |  |  |  |  |  |  | DATE SIGNED <b>11-3-80</b>  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b> ADDRESS <b>111 Penn Street</b>   |  |  |  |  |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  |  |  |  |  |  |  |  |  | 23b. DATE <b>11/6/80</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith</b>  |  |  |  |  |  |  |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b>   |  |
| 24. FUNERAL HOME <b>3331 Brehms Lane, Balto. Md. 21213</b>  |  |  |  |  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>NOV 5 1980</b>   |  |
| 25b. REGISTRAR'S SIGNATURE <u>Timothy McCreedy</u>  |  |  |  |  |  |  |  |  |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

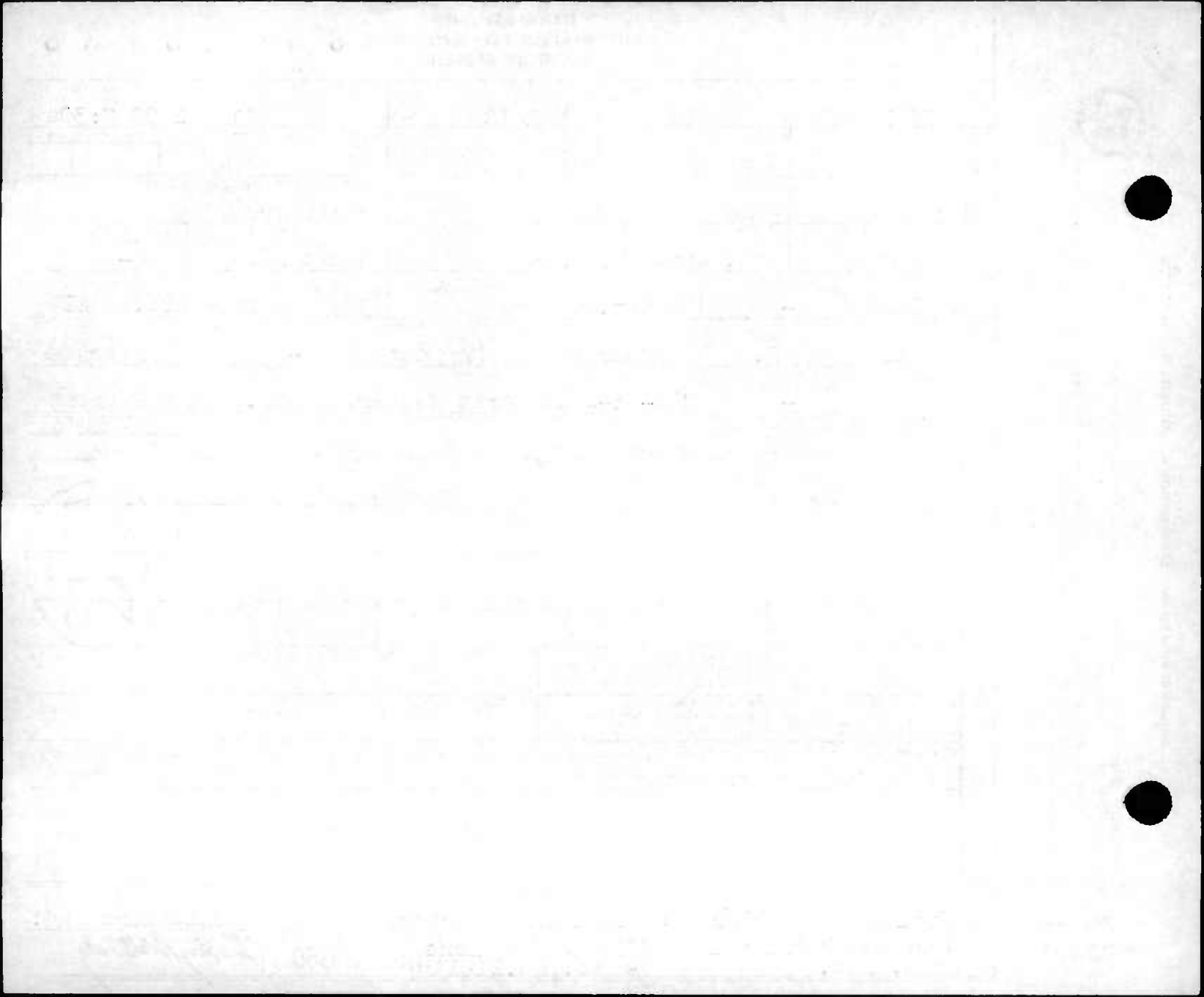
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 1 3 6

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|  |   |   |   |   |   |
|--|---|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>ISABELLE E. HARRIS  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 22 80   |   | 2b. HOUR<br>7:30a.m.  |
| 3. SEX<br>Female   | 4. RACE<br>Caucasian  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>May 5, 1893   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>87 YRS.                                | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Agnes Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                   | 12b. KIND OF BUSINESS OR INDUSTRY<br>-                                    |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |   |   |   |   |   |
| 13a. STATE<br>Maryland   | 13b. COUNTY<br>-  | 13c. CITY OR TOWN<br>Baltimore  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>3823 Bonview Ave., 21213                           |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>James P. McHardy   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Maryann - Kilbride   |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No -   |   | 16b. SOCIAL SECURITY NO.<br>212-05-4513   | 17. INFORMANT<br>ADDRESS<br>Marie Wacker, dgthr., same address                                  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u><br><u>4292</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>CONGESTIVE HEART FAILURE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>ASCUD</u>  |   |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>5 min</u><br><u>7 DAYS</u>  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>INTESTINAL OBSTRUCTION R/O CA OF COLON, DIGITALS TOXICITY</u>  |   |   |   |   |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |   |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11-15-80</u> , 19 <u>80</u> , to <u>11-22</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>11-21</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |   |   |   |   |
| 22b. SIGNATURE<br><u>Anastacio R. De Castro</u>  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                   |   | 22c. DATE SIGNED  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ANASTACIO R. DE CASTRO  |   | 22e. ADDRESS  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |   | 23b. DATE<br>11/25/80   | 23c. NAME OF CEMETERY OR CREMATORY<br>Lorraine Cemetery   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md.   |
| 24. FUNERAL DIRECTOR<br>Schlimmek Funeral Home, Inc.   |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 25 1980  |   | 25b. REGISTRAR'S SIGNATURE<br><u>Anthony McBrady</u>                      |   |





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 28137

REG. NO.

1 - STATE  
REGISTRAR

|  |  |  |  |   |                     |  |
|--|--|--|--|---|---------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Myr A Harris   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11-9-80 |   | 2b. HOUR<br>5:40 AM |  |
| 3. SEX<br>F  |  | 4. RACE<br>Cauc  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>02 04 98                                |                     |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>82 YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |  | 8. IF UNDER 24 HRS<br>HOURS MIN   |                     |  |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 10. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 11. BALTIMORE CITY OR COUNTY OF DEATH<br>Balti City MD.                       |                     |  |
| 12. CITY OR TOWN OF DEATH<br>Balti.  |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Sinai H Sp. |  | 14. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Seamstress |                     |  |
| 15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD. |  | 16. COUNTY<br>Balti.   |  | 17. CITY OR TOWN<br>Balti.  |                     |  |
| 18. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William David Wilhelm  |  | 19. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Florence Alberta Bowen  |  | 20. ADDRESS<br>2525 W. Belvedere Ave  |                     |  |
| 21. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No            |  | 22. SOCIAL SECURITY NO.<br>213 05 0267   |  | 23. INFORMANT<br>C Eileen Henderson 4321 Newport Ave.                         |                     |  |

11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

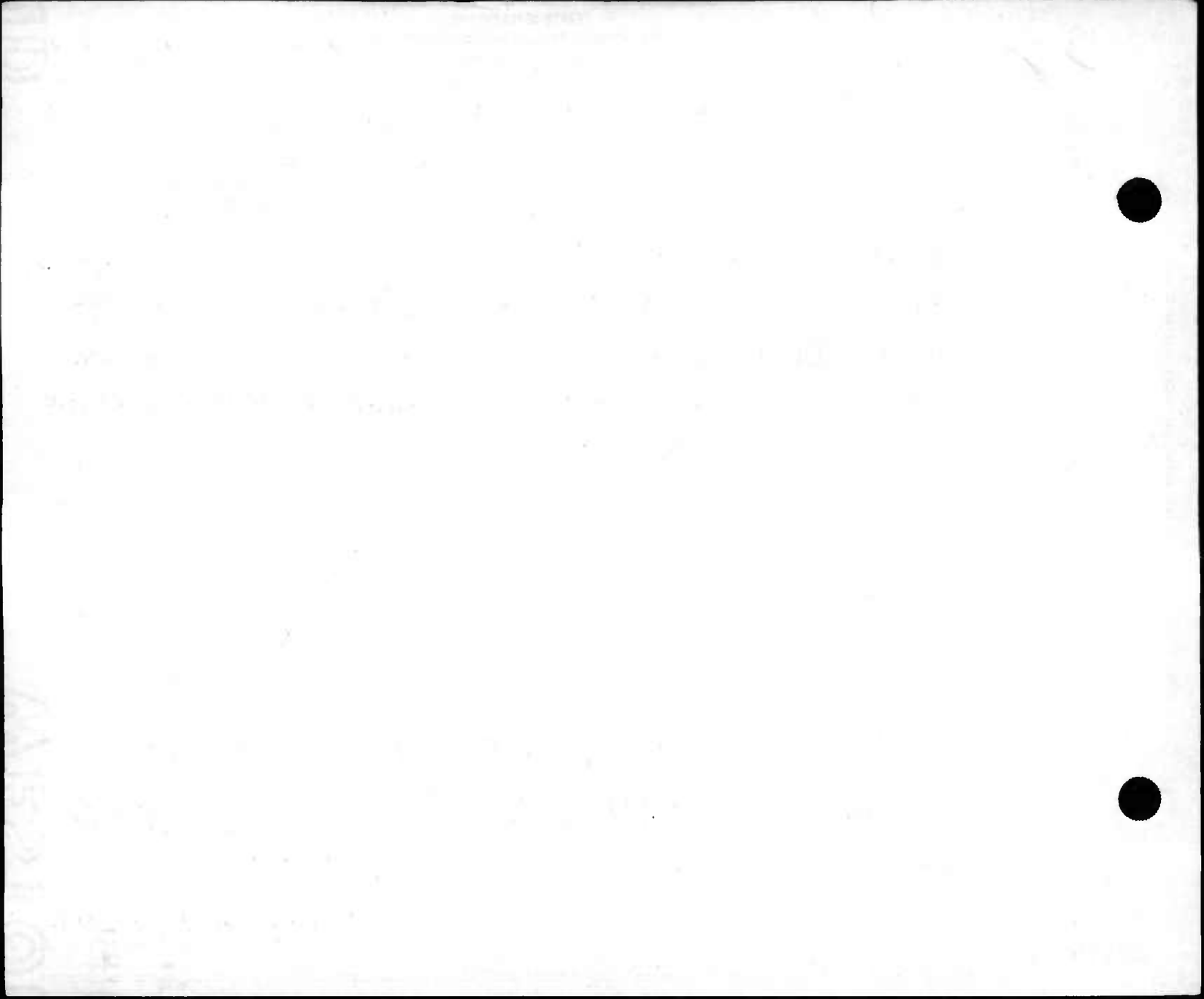
IMMEDIATE CAUSE (a) Respiratory arrest  
7824  
DUE TO, OR AS A CONSEQUENCE OF  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  
(b) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF  
(c) \_\_\_\_\_

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

## PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

Sandice

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10-8</u> 19 <u>80</u> to <u>11-7</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>10-8</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Steve M. Miller MD</u>  |  |  |  | DEGREE<br>MD   |  | 22c. DATE SIGNED<br>11-9-80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Steven M. Miller MD   |  |  |  | 22e. ADDRESS<br>Sinai Hospital   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPEC)<br>Burial   |  | 23b. DATE<br>11/12/80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>St. Abraham's Cem.                             |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Beckleyville Balt. Md.   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>BURGEE FUNERAL HOME  |  |  |  | ADDRESS<br>3631 Falls Rd 21211   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 10 1980   |  |
|  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Robert M. Miller</u>                                |  |  |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                      |  |  |  |  |  |   |  | REG. NO. 28138  |  |
|--|--|----------------------|--|--|--|--|--|---|--|---|--|
| 1- FOR STATE REGISTRAR   |  |                      |  |  |  |  |  |   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Glenn L. Harrod</b>   |  |                      |  |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>11 26 1980</b> |   | 2b. HOUR <b>1:11 AM</b>  |   |  |
| 3. SEX <b>Male</b>   |  | 4. RACE <b>Black</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>8 4 60</b>   |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) <b>20</b> YRS.  |  | IF UNDER 1 YR. MONTHS DAYS  |  | IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>  |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD</b>                      |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sinai Hospital</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE <b>MD</b>   |  | 13b. COUNTY          |  | 13c. CITY OR TOWN <b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 13e. STREET ADDRESS <b>1730 W. Fayette St.</b>  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>John T. Harrod</b>   |  |                      |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Cornelia M. Washington</b>  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>No</b>  |  |                      |  | 16b. SOCIAL SECURITY NO. <b>216-78-6830</b>  |  | 17. INFORMANT ADDRESS <b>Cornelia M. Harrod 1730 W. Fayette</b>  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY: <b>Gunshot Wound of Abdomen (handgun)</b>   |  |                      |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| IMMEDIATE CAUSE (a) <b>9650</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |  |                      |  |  |  |  |  |   |  |   |  |
| (b) <b>DUE TO, OR AS A CONSEQUENCE OF</b>  |  |                      |  |  |  |  |  |   |  |   |  |
| (c) <b>DUE TO, OR AS A CONSEQUENCE OF</b>  |  |                      |  |  |  |  |  |   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                      |  |  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                      |  | 21b. TIME OF INJURY<br>HOUR <b>11:55</b> MONTH DAY YEAR <b>11 25 1980</b> P.M.   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Subject shot</b>  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>restaurant</b>  |  | 21f. LOCATION<br>STREET <b>McDonald's</b> CITY OR TOWN <b>Baltimore</b> COUNTY <b>Co.</b> STATE <b>MD</b><br><b>Restaurant, 5100 York Rd., Baltimore City, Md.</b> |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                      |  |  |  |  |  |   |  |   |  |
| ACTUAL SIGNATURE <b>Virginia L. Dolan</b> M.D.   |  |                      |  |  |  | TITLE (SPECIFY) <b>Assistant</b> MEDICAL EXAMINER  |  |   | DATE SIGNED <b>11/26/80</b>  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>   |  |                      |  |  |  | ADDRESS <b>111 Penn Street</b>   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  |                      |  | 23b. DATE <b>12/1/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem</b>   |  |   | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore</b> COUNTY <b>Co.</b> STATE <b>MD</b> |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Wm. C. March F/H</b> ADDRESS <b>1101 E. North Ave.</b>   |  |                      |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>NOV 28 1980</b>   |  |   | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>                                    |   |  |



*[Faint, illegible handwritten text]*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 1 3 9

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |   |  |   |                      |  |  |
|---|--|---|--|---|----------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MARY MIDDLE LOU LAST HART  |  |   | 2a. DATE OF DEATH<br>MONTH NOVEMBER DAY 22 YEAR 1980 |   | 2b. HOUR<br>06:00 AM |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH 12 DAY 19 YEAR 1931   |                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br>48 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>House Wife  |                      | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home  |  |
| 13a. STATE<br>MARYLAND  |  | 13b. COUNTY<br>Wicomico   |  | 13c. CITY OR TOWN<br>Salisbury  |                      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>IRA THOMAS  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE<br>HILDA Webster   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |                      | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>014-28-8114   |  |
| 17. INFORMANT<br>ADDRESS<br>George W. Hart 816 Riverside Dr.<br>Salisbury, Md 21801   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 1629 Metastatic oat-cell carcinoma<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b):<br>None |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 year  |                      |  |  |
| 19a. DATE OF OPERATION<br>None  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                      |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                      |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/20, 19 80, to 11/22, 19 80, that (I) (we) lost saw the deceased alive on 11/22, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |                      |  |  |
| 22b. SIGNATURE<br>Bruce R. McCurdy  |  | DEGREE<br>MD  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |                      | 22c. DATE SIGNED<br>11/22/80   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Bruce R. McCurdy M.D.  |  | 22e. ADDRESS<br>600 N. Wolfe St. Balto MD 21205   |  |   |                      |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  | 23b. DATE<br>11/25/1980   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Wicomico Mem PK   |                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>SALISBURY, WIC. MD.  |  |
| 24. FUNERAL DIRECTOR<br>(NAME)<br>Hill-Baker-Bounds   |  | ADDRESS<br>Salisbury, Md  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 25 1980  |                      | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |

06/11/82

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 days after death. Part 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.



101 YEAR 1981  
12 11 91

5M130

101 YEAR 1981  
12 11 91

5M130

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

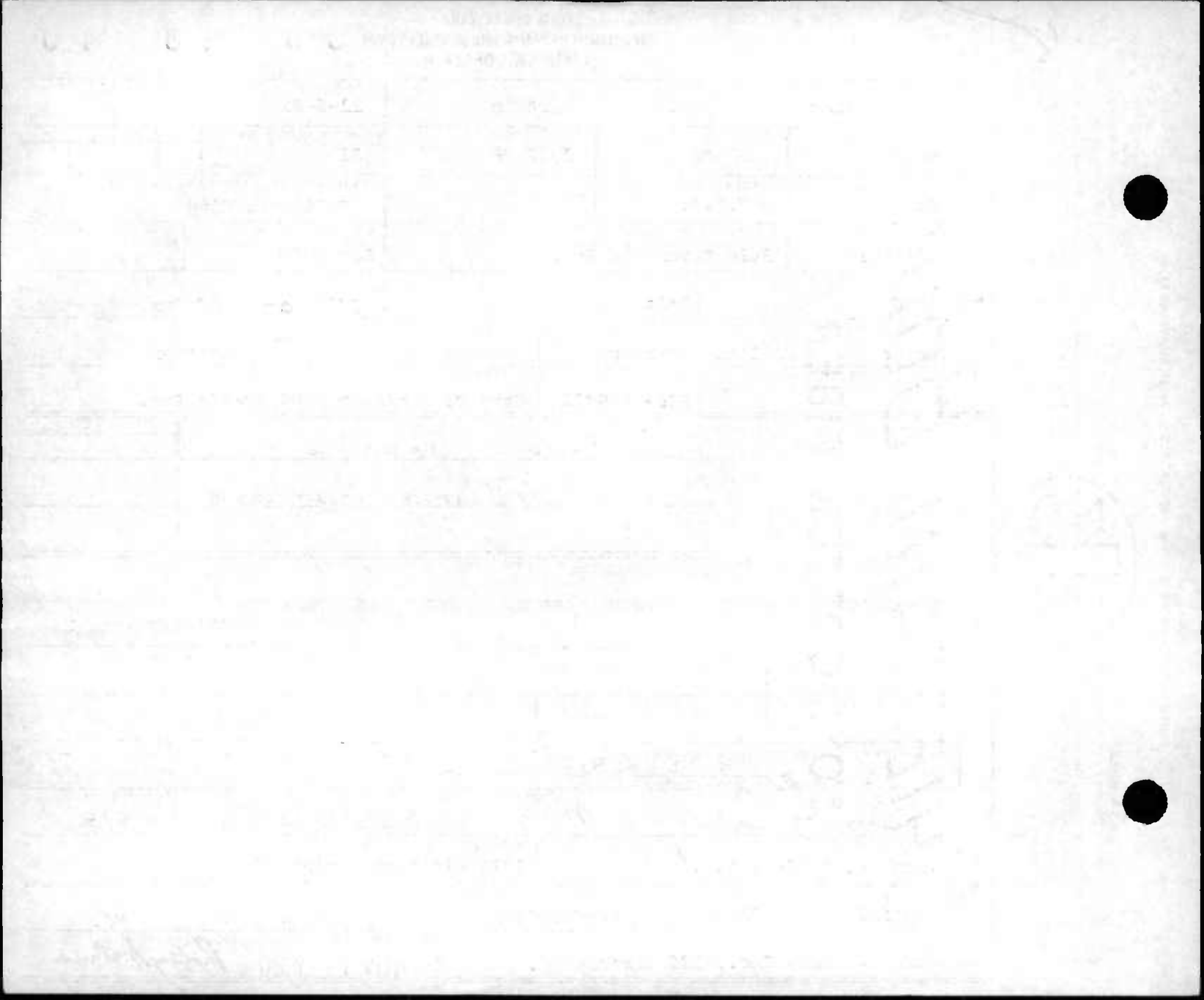
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

2 8 1 4 0

REG. NO.

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Anna C. Hartman   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11-5-80  |  | 2b. HOUR<br>M  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1-17-99   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>81  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3416 Ravenwood Ave.  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George William Sprague  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Daisy Patterson  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>216-09-9411  |  |
| 17. INFORMANT<br>ADDRESS<br>Gary H. Robinson, 5006 Arabia Ave.  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u><br>2500<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>Diabetes Mellitus &amp; Hypertension</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                         |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9-22</u> , 19 <u>80</u> , to <u>Feb 5</u> , 19 <u>80</u> , that (I) (we) lost the deceased alive on <u>9-22</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE<br><u>Larry G. Tilley, M.D.</u><br>DEGREE<br>M.D.<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  | 22c. DATE SIGNED<br><u>11/5/80</u>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Larry G. Tilley, M.D.  |  | 22e. ADDRESS<br>1012 Old North Point Rd.  |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>11-8-80   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowridge   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Dorsey Md.  |  | 24. FUNERAL DIRECTOR<br>NAME<br>Leonard J. Ruck, Inc., 5305 Harford Rd.   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 7 1980  |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>History McCreedy</u>   |  |   |  |   |  |  |  |





**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

80 28141

REG. NO.

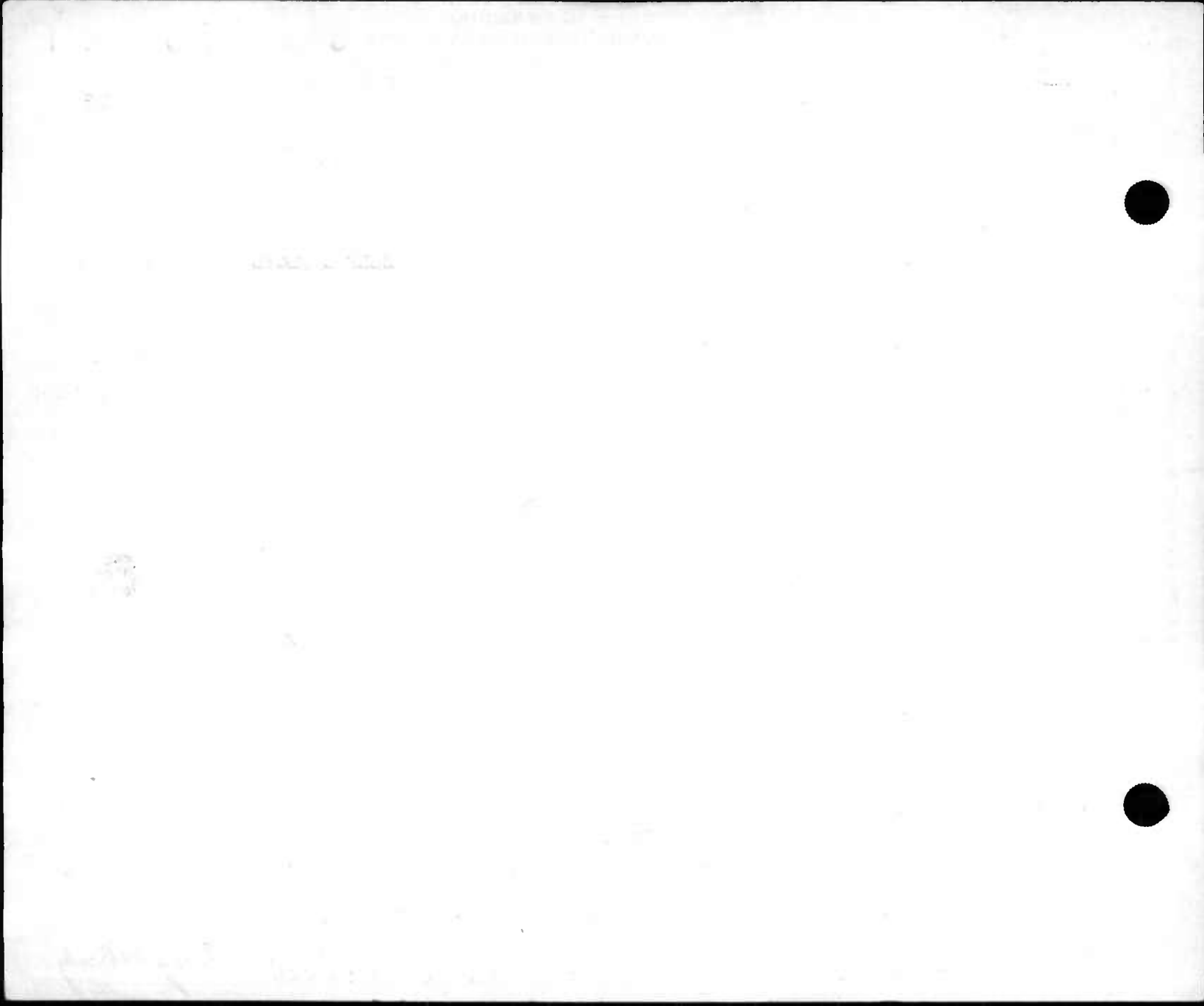
|   |  |  |   |  |   |
|---|--|--|---|--|---|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |   | 2b. HOUR   |   |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST  |  | CLEVELAND HASKINS  |   | 11/1/80 8 <sup>55</sup> P.M.   |   |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH MONTH DAY YEAR  | 6. AGE (IN YEARS LAST BIRTHDAY)                               | 7. IF UNDER 1 YEAR IF UNDER 24 HRS   |   |
| M   | B  | 10 19 04   | 76  | MONTHS DAYS HOURS MIN.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |  |   |
| VIRGINIA  | USA  |  | BALTO CITY MD.  |  |   |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY   |
| Balto City  | SINAI HOSPITAL   |  | SELF EMPLOYED   |  | RESTURANT   |
| 13a. STATE  |  | 13b. COUNTY  | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| MD  | BALTO  | BALTO  | 13e. STREET ADDRESS   |  |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |   | 16. ADDRESS  |   |
| Johannie Haskins  |  | SALLY DANIELS  |   | 4713 Belle Forte Rd. 21208   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO  |   | 17. INFORMANT  |   |
| No  |  | 227-12-1437  |   | Agnes Evans- 4713 Bell Forte Rd. 21208   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1850  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC RENAL FAILURE, METABOLIC ACIDOSIS  |  |  |   |  | Months  |
| DUE TO, OR AS A CONSEQUENCE OF (c) METASTATIC DISEASE - Cancer of Prostate  |  |  |   |  | Years   |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |   |
|   |  | P.M. 19  |   |  |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |
|   |  |  |   |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/23 19 80, to 11/1 19 80, that (I) (we) last saw the deceased alive on 11/1/80 5pm 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |   |
| 22b. SIGNATURE Michael R. Kessler M.D.  |  |  |   | 22c. DATE SIGNED 11/1/80   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL R. KESSLER, M.D.  |  |  |   | 22e. ADDRESS SINAI HOSPITAL OF BALTIMORE, Belvedere Greenspring Balto Md 21205               |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  | 23c. NAME OF CEMETERY OR CREMATORY                            | 23d. LOCATION CITY OR TOWN COUNTY STATE  |   |
| Burial  |  | 11/6/80  | Maryland Natl. Mem.   | Murkirk Maryland   |   |
| 24. FUNERAL DIRECTOR NAME   |  | 25a. DATE REC'D. BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE   |   |
| Herbert E. Nutter-3035 W. North Ave.  |  | NOV 5 1980   |   | [Signature]  |   |

BP  
 DHMH-16 20M  
 (VRA 15, 4) 7/78

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certification completed.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |   |  |  |  |  | REG. NO. 80 28142                                      |  |                  |  |                     |  |
|--|--|---|--|--|---|--|--|--|--|--|--|------------------|--|---------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>ROY NMN HAWKINS   |  |   |  |  |   |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>11 28 80           |  |                  |  | 2b. HOUR<br>7:32A M |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>BLACK  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>9 16 19   |   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br>61                                 |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.              |  | IF UNDER 24 HRS. |  |                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>NORTH CAROLINA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |  |  |                  |  |                     |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>VAMC, LOCH RAVEN, BALTIMORE, MD |  |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>CARPENTER |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                      |  |                  |  |                     |  |
| 13a. STATE<br>MARYLAND   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>BALTIMORE   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>1533 BENTALOU STREET 21216  |  |  |  |                  |  |                     |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>EUGENE HAWKINS  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>DARLING GATLING  |   |  |  |  |  |  |  |                  |  |                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>YES   |  | 16b. SOCIAL SECURITY NO.<br>WW II   |  | 16c. SOCIAL SECURITY NO.<br>244 07 8671  |   | 17. INFORMANT ADDRESS<br>Hazel Elmore 1065 Hendrix Street                            |  |  |  |  |  |                  |  |                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line 1a or (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>4379 IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>R/O Pulmonary embolus</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>General C-V state / TB / post op</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 hour |  |                  |  |                     |  |
| 19a. DATE OF OPERATION<br>11/24/80   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>BPH / Good post op -  |  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |                  |  |                     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |  |  |  |  |                  |  |                     |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |  |  |  |                  |  |                     |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>NOVEMBER 15</u> , 19 <u>80</u> , to <u>NOVEMBER 28</u> , 19 <u>80</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>NOVEMBER 28</u> , 19 <u>80</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (not) view the body after death. |  |   |  |  |   |  |  |  |  |  |  |                  |  |                     |  |
| 22b. SIGNATURE<br><i>Raza Khaul</i>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |  |  | 22c. DATE SIGNED<br>11/28/80   |  |  |  |                  |  |                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>RAZA KHAULI MD.   |  |   |  | 22e. ADDRESS<br>3900 LOCH RAVEN BLVD., BALTIMORE, MD 21218   |   |  |  |  |  |  |  |                  |  |                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>12/1/80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cheltenham Vet Cem.  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Cheltenham, Md.                           |  |  |  |  |  |                  |  |                     |  |
| 24. FUNERAL DIRECTOR<br>WILLIAM C. MARCH FUNERAL HOME INC.   |  |   |  | 1101 E. North Ave.   |   | 25a. DATE REC'D. BY REGISTRAR<br>DEC 2 1980  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Dorothy Kaulsky</i>   |  |  |  |                  |  |                     |  |

1980 DEC 8

*Handwritten signature*

DEC 8 1980

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 1 4 3

REG. NO.

|  |   |  |  |   |   |
|--|---|--|--|---|---|
| 1 DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Gladys Bury Haworth  |   |  | 2a DATE OF DEATH MONTH DAY YEAR<br>Nov 8 80  |   | 2b HOUR<br>1P M   |
| 3 SEX<br>Female  | 4 RACE<br>White   | 5 DATE OF BIRTH MONTH DAY YEAR<br>1-30-1893  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>87 YRS   | 7a UNDER 1 YEAR MONTHS DAYS<br>7b UNDER 24 HRS HOURS MIN.                     |   |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>England  | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |   |   |
| 10 CITY OR TOWN OF DEATH<br>Baltimore  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Long Green Nursing Home |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Home Maker                  |   | 12b KIND OF BUSINESS OR INDUSTRY  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |   |  |  |   |   |
| 13a STATE<br>Maryland  | 13b COUNTY<br>-----   | 13c CITY OR TOWN<br>Baltimore  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e STREET ADDRESS<br>9 St Johns Rd 21210                                     |   |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>Ingram Bury  |   | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Rebecca Galbraith   |  |   |   |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) NO   |   | 16b SOCIAL SECURITY NO.<br>018-26-4114   | 17 INFORMANT ADDRESS<br>Dr R.J.Brandt 9 St Johns Rd 21210                                      |   |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).<br>PART I. DEATH WAS CAUSED BY:<br>4292 IMMEDIATE CAUSE (a) <u>ASCVD</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |   |  |  |   |   |
| 19a DATE OF OPERATION  |   | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>1971   |  | 21f LOCATION CITY OR TOWN COUNTY STATE<br>8 Nov 80                            |   |
| 22a I certify that (I) (this hospital) attended the deceased from 8 Nov 80 to 10 Nov 80, that (I) (we) last saw the deceased alive on 8 Nov 80 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I was) (I was not) (I did not) view the body after death.                                 |   |  |  |   |   |
| 22b SIGNATURE<br>William G Helfrich  |   | DEGREE<br>MD   |  | 22c DATE SIGNED<br>10 Nov 80  |   |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)   |   | 22e ADDRESS<br>5006 Roland Ave. 21210  |  |   |   |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |   | 23b DATE<br>11-14-80   | 23c NAME OF CEMETERY OR CREMATORY<br>Pine Grove Cem  |   | 23d LOCATION CITY OR TOWN COUNTY STATE<br>Whitinsville Mass   |
| 24 FUNERAL DIRECTOR NAME<br>Mitchell-Wiedefeld Home  |   | ADDRESS<br>6500 York Rd 21212  |  | 25a DATE REC'D. BY REGISTRAR<br>NOV 12 1980                                   |   |
|  |   |  |  | 25b REGISTRAR'S SIGNATURE<br>[Signature]                                      |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 0 2 8 1 4 4  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  | REG. NO.   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>MINNIE Rose HAYDEN   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>Nov 6 1980   |  | 2b. HOUR MIN<br>7 10 P M  |  |
| 3 SEX<br>FEMALE  |  | 4 RACE<br>White   |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>10 23 24   |  | 6 AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS<br>56  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>City of BALTO MD.  |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Sinai Hosp. |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Md. 13b. COUNTY A.A. 13c. CITY OR TOWN Glen Burnie  |  |   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS<br>5806 Ritchie St.   |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>William Geiglein   |  |   |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Lucille Krauss  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>218 18 9764   |  | 17 INFORMANT ADDRESS<br>John J. Hayden same as 13 e  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1629 Metastatic Small cell carcinoma of Lung<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (b) Metastasis to CNS, Pericardium Liver.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/17/80 to 11/6/80, that (I) (we) last saw the deceased alive on 11-6-80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) did (did not) view the body after death.  |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br>Claudio Levin  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |  | 22c. DATE SIGNED<br>11/6/80   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Claudio Levin   |  |   |  | 22e. ADDRESS<br>Sinai Hospital   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>11/10/80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Glen Haven Mem Pk  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Glen Burnie A.A. Md.   |  |
| 24 FUNERAL DIRECTOR NAME<br>George J. Gonce  |  |   |  | ADDRESS<br>Balto 21225 4001 Ritchie Hgwy.  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 10 1980  |  |
|  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |   |  |

ST 59



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8028145

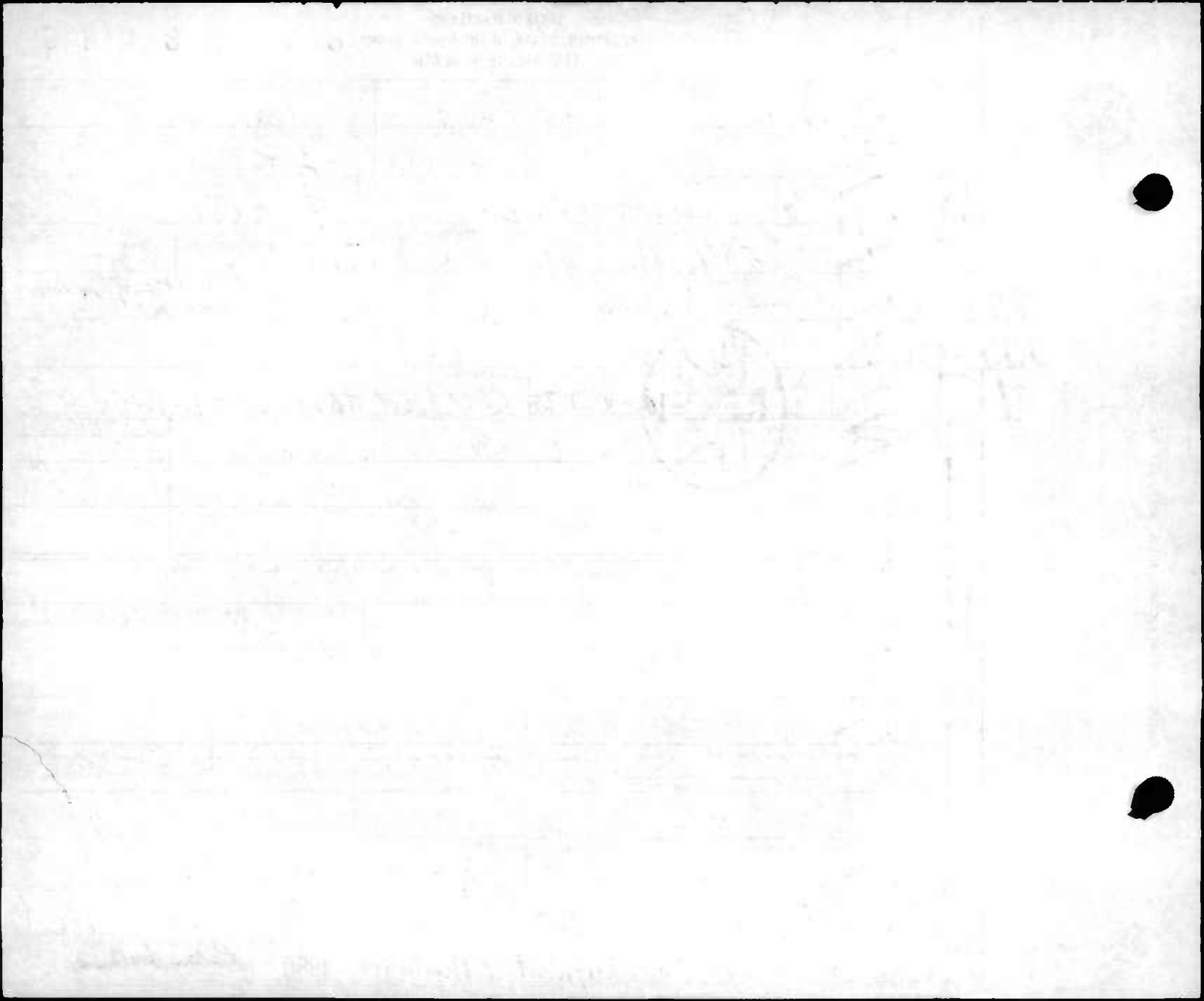
1 - FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |  |                                   |
|--|--|---|---|--|-----------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Gracie HAZZARD   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>NOV. 26 '80  |  | 2b. HOUR<br>M                     |
| 3. SEX<br>Female   | 4. RACE<br>Black   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6 4 12  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>68 YRS.   |                                   |
| 7a. BIRTH PLACE<br>(STATE OR FOREIGN COUNTRY)<br>Wheeling W. Va.   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                            |                                   |
| 10. CITY OR TOWN OF DEATH<br>Balto   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>5377 Stonington Ave |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Teacher                     |  | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE<br>MD   | 13b. COUNTY  | 13c. CITY OR TOWN<br>Balto  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Arch Meade   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Unknown  |   |  |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.<br>218-30-5185   |   | 17. INFORMANT<br>ADDRESS<br>Clifford Hazzard 511. Rosedale St                        |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Pul. Abt. Cerebrovascular Accident? mins<br>4029<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Hypertensive C-V Disease? years<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)          |  |   |   |  |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>Chronic Brain Syndrome   |  |   |   |  |                                   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |                                   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                   |
| 22a. I certify that (I) (this hospital) attended the deceased from FEB 1975 to 10/24 1980, that (I) (we) last saw the deceased alive on 10/24 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |  |                                   |
| 22b. SIGNATURE<br>E. Saunders  |  | DEGREE<br>MD  |   | 22c. DATE SIGNED<br>11/28/80   |                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ELIJAH SAUNDERS   |  | 22e. ADDRESS<br>2850 Liberty Heights Ave  |   |  |                                   |
| 23a. BURIAL-CREMATATION, REMOVAL<br>(SPECIFY)<br>Burial  | 23b. DATE<br>12-2-80   | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md                           |                                   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Melvin A. Evans  |  | ADDRESS<br>3037 Kyrin Falls Pl  |   | 25a. DATE REC'D. BY REGISTRAR<br>DEC 1 1980  |                                   |
|  |  | 25b. REGISTRAR'S SIGNATURE<br>Dorothy Roberts   |   |  |                                   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Page 3 should be filed within 180 days after death. The medical examiner or attending physician should be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |   |  |  |  |   |  | 8028146  |  |
|--|--|---|--|---|--|--|--|---|--|--|--|
| 1 - FOR STATE REGISTRAR  |  |   |  |   |  |  |  |   |  | REG. NO.   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>William J. Heddrick, Sr.  |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 12 80                                    |  |   | 2b. HOUR<br>105 P.M.   |  |  |
| 3. SEX<br>male   |  | 4. RACE<br>white  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>01 22 18  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>62 YRS.   |  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.           |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Baltimore, Md.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>CITY MD.                                   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>S Balto Gen-1 Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Security Guard |  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a. STATE<br>Md.  |  |   |  |   |  | 13b. COUNTY<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>346 BIGLEY AVE  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Henry Heddrick   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lena Hundertmark   |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> (IF YES, GIVE YEAR OR DATES)<br>YES   |  |   |  | 16b. SOCIAL SECURITY NO.<br>214-03-4200   |  | 17. INFORMANT<br>Baltimore, Md. 21227<br>Mrs. Donotha Heddrick 346 Bigley Avenue   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>1629</u><br>(b) <u>squamous cell carcinoma of lung</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>probable pneumonia @ upper lobe</u> |  |   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>~ 10 min.<br>9 mos.<br>few weeks   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)     |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/10/80</u> , 19 <u>80</u> , to <u>11/12</u> , 19 <u>80</u> , that (I) (we) lost <u>11/12</u> <u>19 80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br>Barbara Fretwell   |  |   |  |   |  | DEGREE<br>MD   |  |   | 22c. DATE SIGNED<br>11-12-80   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Barbara Fretwell  |  |   |  |   |  | 22e. ADDRESS<br>S Balto Gen-1 Hosp 3001 S Hanover Balto 21230                      |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |   |  | 23b. DATE<br>11/15/80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Glen Haven Mem. Park                         |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Glen Dinnie Anne Arundel Md. |  |  |
| 24. FUNERAL DIRECTOR<br>McCutty Funeral Home of Brooklyn<br>237 E. Patapsco Avenue Baltimore, Md. 21225  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 12 1980                                       |  | 25b. REGISTRAR'S SIGNATURE<br>Anthony McCreedy  |  |  |  |

SECRET

XXXXXXXXXX

DR. S. J. VON

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80

28147

REG. NO.

1. FOR  
STATE  
REGISTRAR1. DECEASED NAME  
(TYPE OR PRINT)

JOSEF (JOSEPH) F. HEINRICHS

20. DATE OF DEATH MONTH DAY YEAR 11-28-80 26. HOUR 8<sup>15</sup> PM

3. SEX

M

4. RACE

W

5. DATE OF BIRTH

12-7-1902

6. AGE (IN YEARS LAST BIRTHDAY)

78

IF UNDER 1 YEAR

MONTHS DAYS

IF UNDER 24 HRS

HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

GERMANY

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

BALTIMORE CITY MD.

10. CITY OR TOWN OF DEATH

BALTIMORE

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

UNION MEMORIAL HOSPITAL

12a. USUAL OCCUPATION  
(TYPE OF WORK FOR MOST OF WORKING LIFE)

Tool &amp; Die Maker

12b. KIND OF BUSINESS OR INDUSTRY

MACHINIST.

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE MD.

13b. COUNTY

—

13c. CITY OR TOWN BALTO.

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

5203 EUGENE AVE.

14. FATHER'S NAME

JOSEF

MIDDLE

HEINRICHS

15. MOTHER'S MAIDEN NAME

UNKNOWN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO OR UNKNOWN)

No

16b. SOCIAL SECURITY NO.  
(IF YES, GIVE WAR OR DATES)

214-01-3170

17. INFORMANT

Mrs. Madelon T. Heinrichs - 5203 Eugene Ave.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Aspiration Pneumonia

4360

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Right CVA

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

3 days

21 days

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Atrial Fibrillation

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

NO

21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (if (this hospital) attended the deceased from 11/27, 1980, to 11/28, 1980, that (we) lost saw the deceased alive on 11/28, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.

22b. SIGNATURE

James C. Jarrell

DEGREE

MD

ATTENDING PHYSICIAN ☐MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☒

22c. DATE SIGNED

11/28/80

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

James C. Jarrell

22e. ADDRESS

Union Mem'l Hosp., Balto MD 21218

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

BURIAL

23b. DATE

12-2-80

23c. NAME OF CEMETERY OR CREMATORY

LORRAINE PARK

23d. LOCATION

CITY OR TOWN

BALTO., MD

COUNTY

STATE

24. FUNERAL DIRECTOR

Harley Miller - 7527 Harford Rd.

25a. DATE REC'D. BY REGISTRAR

DEC 1 1980

25b. REGISTRAR'S SIGNATURE

Betsy Helms

JOSEPH [redacted]

X BATHING CITY

UNION MEMORIAL HOSPITAL

BATHING

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 8 0 2 8 1 4 8  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1 - FOR<br>STATE<br>REGISTRAR  |  |  |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>NANNIE MAE HENDRICKSON</b>  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 5 80</b>  |  | 2b. HOUR<br><b>11:30 AM</b>  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 22 01</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>79</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Va</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Good Samaritan Hosp.</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Domestic</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Private</b>  |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>Balto.</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George Drummond Kidd</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>                                    |  |  |  |
|  |  | 16b. SOCIAL SECURITY NO.<br><b>25-22-4646</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>5710</b><br><b>Lawrence Blackwell Northwood Dr.</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b><br><b>3489</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>BRAIN DAMAGE</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Antonio Sergio Cassanego</b>  |  |  |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>11/5/80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Antonio Sergio Cassanego</b>   |  |  |  | 22e. ADDRESS<br><b>Good Samaritan Hospital</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Removal</b>   |  | 23b. DATE<br><b>11-8-80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olive Church City Broadvax</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Va.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Randolph J. Collick</b>   |  |  |  | ADDRESS<br><b>2431 E. Oliver St.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 10 1980</b>  |  |
|  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Rafael McBrady</b>  |  |  |  |

BP



5,

1948

216

3-21 1240

John D. Smith



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80

281

49

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST MIDDLE LAST<br>BABY BOY HENSON   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>NOVEMBER 13, 1980  |  | 2b. HOUR<br>12:05 PM   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Black   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 04 80  |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br>10 days   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Balto., Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>yes U.S.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>JOHNS HOPKINS HOSPITAL  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>N/A   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Md.  |  | 13b. COUNTY<br>U.S. Balto. Md.   |  | 13c. CITY OR TOWN<br>Balto.   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>Harry A. Henson   |  | 15. MOTHER'S MAIDEN NAME<br>Faye B. Harriston  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>n/a   |  |
| 17. INFORMANT<br>ADDRESS<br>4409 Fairview Ave. (Mr. Harry A. Henson)   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u><br>2706<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>SHOCK</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <u>HYPERAMMONEMIA</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>NONE</u> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |
| 19a. DATE OF OPERATION<br>11/7   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>DIALYSIS   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/7</u> , 19 <u>80</u> , to <u>11/13</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>11/13</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE<br><u>Joan Y. Reece</u>   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br>11/13/80   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JOAN Y. REECE   |  | 22e. ADDRESS<br>JOHNS HOPKINS HOSP., 30, MD. 21205   |  | 23a. BURIAL, CREMATION, REMOVAL<br>15 <u>Burial</u>   |  | 23b. DATE<br>11/17/80  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>King Park  |  | 23d. LOCATION<br>BALTO., MD. COUNTY STATE  |  | 24. FUNERAL DIRECTOR<br>NAME<br>Leroy O. Dyett  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 17 1980   |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>R. J. McHenry</u>   |  | 25c. ADDRESS<br>4600 Liberty Heights Ave.  |  | 25d. DATE REC'D. BY REGISTRAR<br>NOV 17 1980  |  |  |  |



100

100

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 1 5 0

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |  |  |  |  |   |  |  |  |   |  |
|--|--|--|--|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CHARLES LEONARD HENSON</b>  |  |  | 2a. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>4</b> YEAR <b>80</b> |  |  | 2b. HOUR <b>11:20</b> AM  |  |  |  |   |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>BLACK</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>2</b> DAY <b>24</b> YEAR <b>1915</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b> YRS  |  | 7. IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>  |  | 7. IF UNDER 24 HRS<br>HOURS <b>0</b> MIN <b>0</b> |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>  |  | 9. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 11. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD</b>                               |  |  |  |   |  |
| 12. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNIVERSITY OF MARYLAND</b> |  |  |  | 14. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>CARPENTER</b>             |  | 15. KIND OF BUSINESS OR INDUSTRY<br><b>MARYLAND GOVT</b>   |  |   |  |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>ANNAPOLIS</b> 13b. COUNTY <b>MD</b> 13c. CITY OR TOWN <b>MD</b>   |  |  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>170 BROWNS WOODS ROAD</b>  |  |   |  |
| 14. FATHER'S NAME<br>FIRST <b>CHARLES</b> MIDDLE <b>CARROLL</b> LAST <b>HENSON</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>AGNES</b> MIDDLE <b>H</b> LAST <b>JOHNSON</b>   |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>218-09-5279</b>   |  | 17. INFORMANT<br>ADDRESS <b>6504 ACORN CT CAMP SPRINGS MD</b>                                   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Dehydration &amp; ANOREXIA</b><br><b>1889</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>TERMINAL BLADDER CANCER</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>6 MONTHS</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> |  |  |  |  |  |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:<br><b>NONE</b>   |  |  |  |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION<br><b>10/6/80</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>BOWEL OBSTRUCTION</b>   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>9/29</b> 19 <b>80</b> to <b>10/25</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>11-4</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                       |  |  |  |  |  |   |  |  |  |   |  |
| 27b. SIGNATURE<br><b>William P. Reed, Jr.</b>  |  |  |  | DEGREE <b>MD</b>   |  |   |  | 27c. DATE SIGNED<br><b>11-4-80</b>   |  |   |  |
| 27d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>WILLIAM FIPER REED, JR.</b>  |  |  |  | 27e. ADDRESS<br><b>22 J. GREENE ST BALTIMORE MD 21201</b>  |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>SPECIFY <b>BURIAL</b>   |  | 23b. DATE<br><b>11-8-1980</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ASBURY BROADNECK CEME.</b>  |  | 23d. LOCATION<br>CITY OR TOWN <b>St. Marys</b> COUNTY <b>A.A.</b> STATE <b>Maryland</b>         |  |  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>WILLIAM REESE &amp; SONS MORTUARY, P.A.</b> ADDRESS <b>Annapolis, Md.</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 5 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>P. Reed</b>  |  |  |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

*[Faint, illegible handwritten notes and markings are visible across the page.]*

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

2 8 1 5 1

REG. NO.

|   |  |  |  |   |   |   |  |  |
|---|--|--|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><u>Louise D Herbert</u>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><u>11 26 80</u> |   | 2b. HOUR<br><u>4:20 PM</u>  |   |  |  |
| 3. SEX<br><u>Female</u>   |  | 4. RACE<br><u>White</u>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><u>6 16 1994</u>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS HOURS MIN.<br><u>85</u>                     |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>Baltimore</u>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S. A.</u>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Baltimore city</u> MD.                               |  |  |
| 10. CITY OR TOWN OF DEATH<br><u>Baltimore</u>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>4501 Old Frederick Rd.</u> |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>Retail Sales</u> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>Retired</u>  |  |
| 13a. STATE<br><u>Md</u>   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><u>Wyman Park</u>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><u>William Dunrock</u>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE<br><u>Nannie UNKNOWN</u>  |  | 16. SOCIAL SECURITY NO.<br><u>216-03-4578</u>   |   |   |  |  |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><u>no</u>   |  | 17b. SOCIAL SECURITY NO.<br><u>216-03-4578</u>   |  | 17. INFORMANT<br>ADDRESS<br><u>Same as 10 &amp; 11</u><br><u>Uplands Home for Church Women</u>  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause pending for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio-Pul. arrest</u><br><u>4292</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arterio-sclerotic disease - CHF</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic disease</u> |  |  |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>               |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov. 15</u> 19 <u>80</u> to <u>Nov. 26</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>Nov. 15</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |   |   |  |  |
| 22b. SIGNATURE <u>[Signature]</u>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |   | 22c. DATE SIGNED<br><u>11-28-80</u>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Dr. George Angor</u>  |  |  |  | 22e. ADDRESS<br><u>3350 Wilkens Dre - Baltimore</u>   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>Burial</u>   |  | 23b. DATE<br><u>12/1/80</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Baltimore Cemetery</u>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Baltimore Maryland</u>                         |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><u>Witzke Funeral Home of Catonsville</u><br><u>1630 Edmondson Ave Catonsville, Md. 21228</u>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><u>NOV 28 1980</u>   |   | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed within 72 hours after death. The funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



*[Faint handwritten signature]*

DATE: 8.3.1964

1

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 1 5 2

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|   |  |   |  |   |  |  |
|---|--|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Sabina C Hevell</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 17, 1980</b>  |   | 2b. HOUR<br><b>10:50P M</b>                                    |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 13 1904</b>  |  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS<br>HOURS MIN.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |   |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>  |  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |   |  |  |
| 13a. STATE <b>Md.</b> 13b. COUNTY 13c. CITY OR TOWN <b>Baltimore</b> 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <b>5710 Alameda</b>  |  |   |  |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Fred Zang</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Caroline</b> |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>162 07 9135B</b>   |  | 17. INFORMANT ADDRESS<br><b>Graham R. Hevell Same</b>   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma of the Breast</b><br><b>1749</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                        |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 years</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |
| 22a. I certify that <b>3</b> (this hospital) attended the deceased from <b>October 3</b> , 19 <b>80</b> , to <b>November 17</b> , 19 <b>80</b> , that <b>x</b> (we) lost <b>1</b> saw the deceased alive on <b>November 17</b> , 19 <b>80</b> , and that in <b>(x)</b> (our) opinion death occurred on the date and hour and from the causes stated above, <b>1</b> (we) (did) (not) view the body after death. |  |   |  |   |  |  |
| 22b. SIGNATURE<br><b>Dr. Joseph A. Gent MD</b>  |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>11/17/80</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Joseph A. Gent, M.D.</b>  |  | 22e. ADDRESS<br><b>C/O Maryland General Hospital</b>  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>11/21/1980</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greenmount Cemetery</b>  |  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md</b>   |  |   |  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Mitchell-Wiedefeld Home 6500 York Rd.</b>  |  |   |  | 25a. DATE RECD. BY REGISTRAR<br><b>NOV 21 1980</b>  |  |  |
|   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |  |

MEDICAL CERTIFICATION

2748 BP 10



*[Faint, mostly illegible text, possibly a ledger or form with multiple columns and rows.]*



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 1 5 3

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |  |   |   |  |  |  |
|--|--|--|--|---|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>LETITIA HIGGINBOTHAM</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 11 80</b>                 |   |  | 2b. HOUR<br><b>10:50PM</b>  |   |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Negro</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 16 13</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS.   |   | 7. ORDER 1 YEAR IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. <b>BALTIMORE CITY OR COUNTY OF DEATH</b><br><b>Baltimore City</b> MD.                            |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>CHURCH HOME HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                    |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a. STATE<br><b>MD</b>  |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>                    |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>817 E. Coldspring Lane</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Walter Higginbotham</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Millie Lee</b>     |   |  |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>215-34-7525A</b>  |  | 17. INFORMANT ADDRESS<br><b>Harold Dett 8317 Thornton Rd.</b>   |  |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO-RESPIRATORY ARREST</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>METASTATIC CARCINOMA OF LUNG</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF |  |  |  |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |   |  |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                           |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                      |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11-10</b> , 19 <b>80</b> , to <b>11-11</b> , 19 <b>80</b> , that (I) (we) lost<br>saw the deceased alive on <b>11-11</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                    |  |  |  |   |  |   |   |  |  |  |
| 22b. SIGNATURE<br><i>V. Balakrivhnan</i> DEGREE  |  |  |  |   |  | 22c. DATE SIGNED<br><b>11-11-80</b>   |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>V. BALAKRIVHNNAN, M.D.</b>   |  |  |  |   |  | 22e. ADDRESS<br><b>CHURCH HOSPITAL CORPORATION 2123<br/>100 NORTH BROADWAY, BALTIMORE, MARYLAND</b> |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>11/15/80</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Church Cem.</b> |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Long Green MD</b>                              |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H 1101 E. North Ave.</b>   |  |  |  |   |  | 25. DATE REC'D. BY REGISTRAR<br><b>NOV 12 1980</b>  |   |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of the death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

*Handwritten signature*

NOV 13 1980

C

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 28154

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |                         |   |  |  |  |  |  |
|---|--|--|--|---|-------------------------|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>SR. MARY V. HIGGINS O.S.F.  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 18, 1980 |   | 2b. HOUR<br>1741 P<br>M |   |  |  |  |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Nov. 5, 1902  |                         | 6. AGE (IN YEARS LAST BIRTHDAY)<br>78 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Mass.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                         | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Union Memorial Hospital |  |   |                         | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Religious Sister            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Education                                       |  |  |  |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |   |                         |   |  |  |  |  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore  |                         | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>3725 Ellerslie Avenue   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Thomas Higgins  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Bailey  |                         |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>230 70 0685  |                         | 17. INFORMANT<br>ADDRESS<br>Sr. Cecilia, St. Elizabeth's Convent, Balto., Md.                   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Thrombosis</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASCVD</u><br>4100<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |                         |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Recent<br>Recent<br>Yes  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |                         |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                         |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                         | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                         | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital attended the deceased from <u>10/29</u> 19 <u>80</u> to <u>11/18</u> 19 <u>80</u> , that (I) <u>we</u> last saw the deceased alive on <u>10/29</u> 19 <u>80</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)                                     |  |  |  |   |                         |   |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Ruperto Manankil</u>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |                         |   |  | 22c. DATE SIGNED<br>11-19-80   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Ruperto Manankil, M.D.   |  |  |  | 22e. ADDRESS<br>6600 Belair Road Balto., Md.  |                         |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |  |  | 23b. DATE<br>11/21/80   |                         | 23c. NAME OF CEMETERY OR CREMATORY<br>St. Eliz. Convent   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto., Md.                            |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., Md. 21212   |  |  |  |   |                         | 25a. DATE REC'D. BY REGISTRAR<br>NOV 20 1980  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Ruperto Manankil</u>                                |  |  |  |



1. GARY V. FICIN, 171 Overport, 1932

1932 Nov. 2, 1932

U. S. District Court

Union National Bank

1932

1932

1932

1932

1932

1932

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80

28155

REG. NO.

|  |  |   |   |   |                           |  |
|--|--|---|---|---|---------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>HIGHSMITH, Martha</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 11 5 80</b> |   | 2b. HOUR<br><b>11 4 M</b> |  |
| 3. SEX<br><b>F</b>   |  | 4. RACE<br><b>B</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 12 1913</b>  |                           |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b>   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>YRS.</b>  |   | 8. IF UNDER 24 HRS<br>HOURS MIN.<br><b>YRS.</b>   |                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Va.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                           |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto City</b>  |  | 10. CITY OR TOWN OF DEATH<br><b>Balto</b>   |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Bon Secours Hosp.</b>                       |                           |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |   | 13a. STREET ADDRESS<br><b>2036 Hollins St.</b>  |                           |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md</b>  |  | 13b. COUNTY<br><b>Balto</b>   |   | 13c. CITY OR TOWN<br><b>Balto</b>   |                           |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charlie Owens</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lillie E???</b>   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |                           |  |
| 16b. SOCIAL SECURITY NO.<br><b>213-12-3525</b>   |  | 17. INFORMANT<br><b>Pt's Chart.</b>   |   | ADDRESS   |                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4360</b> IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |   |   |                           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>CVA &amp; Hemiparesis</b>   |  |   |   |   |                           |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                           |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |                           |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                           |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  | 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |   |   |                           |  |
| 22b. SIGNATURE<br><b>Daliah Shamsuddin</b>   |  | DEGREE<br><b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input type="checkbox"/>   |   | 22c. DATE SIGNED<br><b>11/6/80</b>  |                           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DALIAH SHAMSUDDIN</b>  |  | 22e. ADDRESS  |   |   |                           |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPRINT)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>11-11-80</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT Auburn Cem</b>  |                           |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md</b>  |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>BROWN-THOMPSON F.H. 1913 W. BALTO ST.</b>  |   |   |                           |  |
| 25a. DATE REC'D BY REGISTRAR<br><b>NOV 10 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |   |   |                           |  |

BP



74

1944-1945

1944-1945

1944-1945



1944-1945

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 0 2 8 1 5 6

|  |  |  |  |  |  |   |  |  |   |  |  |
|--|--|--|--|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>BERTHA</b>  |  |  | FIRST MIDDLE LAST <b>HILL</b>  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>11/11/80</b>  |  |  | 2b. HOUR <b>12:19</b> M   |  |  |
| 3. SEX <b>Female</b>   |  |  | 4. RACE <b>Negro</b>   |  |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>8 6 06</b>   |  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD   |  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Union Memorial Hosp.</b>                             |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>MD</b>                                       |  |  | 13b. COUNTY  |  |  | 13c. CITY OR TOWN <b>Baltimore</b>  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>John J. Green</b>   |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>   |  |  | 16b. SOCIAL SECURITY NO <b>217-14-2053</b>  |  |  |
| 17. INFORMANT ADDRESS <b>Cornell Hill 720 Bartlett Ave.</b>  |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4279 Congestive heart Failure</b> |  |  | DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cardiac Arrhythmia</b>  |  |  | DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                 |  |  |  |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>11 11 1980</b>   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  | 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                  |  |  |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  | 22a. I certify that (1) (this hospital) attended the deceased from <b>11/11/80</b> to <b>11/11/80</b> , that (1) we last saw the deceased alive on <b>11/11/80</b> , and that in (my) <b>our</b> opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> we (did) <input type="checkbox"/> did not view the body after death. |  |  | 22b. SIGNATURE <b>Benjamin K. Yorkoff MD</b> DEGREE <b>MD</b>   |  |  |
| 22c. DATE SIGNED <b>11/11/80</b>   |  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Benjamin K. Yorkoff MD</b>  |  |  | 22e. ADDRESS <b>Union Memorial Hospital</b>   |  |  | 22f. REGISTRAR'S SIGNATURE <b>Putney</b>  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  |  | 23b. DATE <b>11/15/80</b>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Md. Nat'l Mem. Pk.</b>  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Laurel MD</b>  |  |  |
| 24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H</b>  |  |  | ADDRESS <b>1101 E. North Ave.</b>  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>Nov 12 1980</b>  |  |  | 25b. REGISTRAR'S SIGNATURE <b>Putney</b>  |  |  |

511

Chicago

1910

Chicago, Ill. Jan. 10, 1910

My dear Mr. [illegible]

I have just received your letter of the 8th inst.

and am glad to hear that you are interested in the

subject of the [illegible] of the [illegible]

Very truly yours,  
[illegible]



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80

28157

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |  |  |  |  |   |  |  |  |  |  |
|---|--|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Ethel M. Hill</b>  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>11 7 80</b> |  |  | 2b. HOUR<br><b>6:08 A.M.</b>  |  |  |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 25 24</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>55</b> YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>55</b> |  | 8. IF UNDER 24 HRS.<br>HOURS MIN.<br><b>55</b> |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>IN SC</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY</b> MD.   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALT.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Univ. Md. Hosp</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOME MAKER</b>           |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD</b> 13b. COUNTY <b>Balt. City</b> 13c. CITY OR TOWN <b>Balt.</b> |  |  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET ADDRESS<br><b>2508 W. FRANKLIN ST.</b> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>OTIS HILL</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>EFFIE BURNSIDE</b>   |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>UNK</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>220-12-5404</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Inpatient Regist Form.</b>                                       |  |  |  |  |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a).

**Vascular collapse**

DUE TO, OR AS A CONSEQUENCE OF

(b).

**cardiopulmonary arrest**

DUE TO, OR AS A CONSEQUENCE OF

(c).

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

MEDICAL CERTIFICATION

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |
| 22a. I certify that (a) (this hospital) attended the deceased from <b>11/7</b> 19 <b>80</b> , to <b>11/7</b> 19 <b>80</b> , that (b) (we) last saw the deceased alive on <b>11/7</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Scott Young MD, PhD</b>  |  |  |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>11/7/80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Scott Young</b>   |  |  |  | 22e. ADDRESS<br><b>U. Md. Hosp</b>   |  |   |  |

|   |  |                              |  |   |  |   |  |
|---|--|------------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b> |  | 23b. DATE<br><b>11-11-80</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem Park</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALT. CO. MD</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Joseph L. Russ</b>         |  |                              |  | ADDRESS<br><b>2222 W. North Ave</b>                           |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 12 1980</b>               |  |
|   |  |                              |  | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony McCreedy</b>         |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1911-12

1911-12

1911-12

1911-12

1911-12

1911-12

1911-12

1911-12

1911-12

1911-12

1911-12

1911-12

1911-12

1911-12

1911-12

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 1 5 8

1 - FOR  
STATE  
REGISTRAR

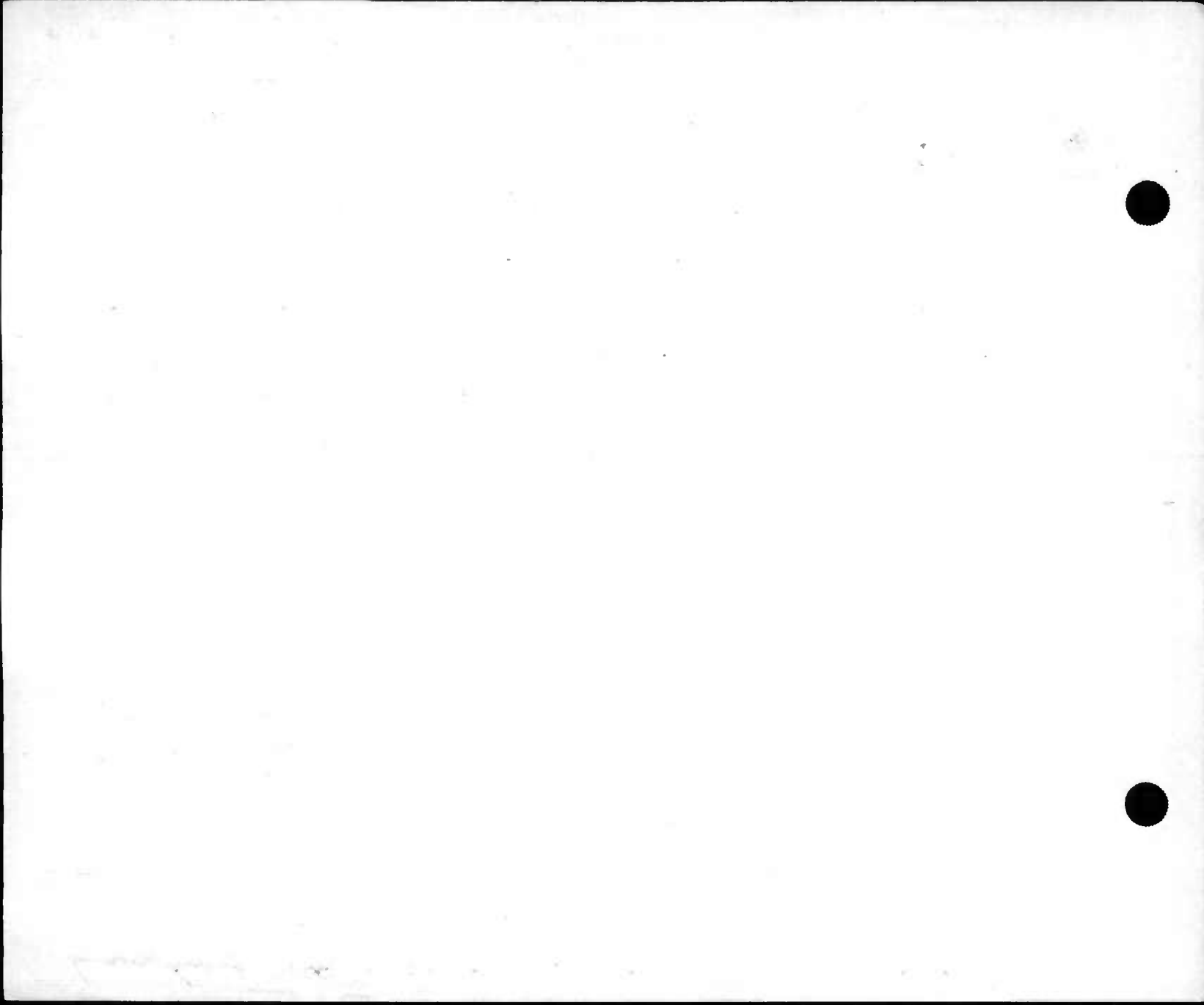
REG. NO.

|  |  |  |  |  |               |   |  |  |  |                               |  |
|--|--|--|--|--|---------------|---|--|--|--|-------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>HOWARD F. HILL   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 30, 1980 |  | 2b. HOUR<br>M |   |  |  |  |                               |  |
| 3 SEX<br>Male  |  | 4 RACE<br>Negro  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>10 5 12   |               | 6 AGE (IN YEARS LAST BIRTHDAY)<br>68<br>YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>✓   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |               | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                       |  |  |  |                               |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2022 W. Lanvale St. |  |  |               | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                               |  |
| 13a. STATE<br>MD   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore   |               | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>2022 W. Lanvale St.   |  |                               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Herbert Hill Sr.   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST  |               |   |  |  |  |                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |  | 16b. SOCIAL SECURITY NO<br>215-05-8677   |  | 17 INFORMANT ADDRESS<br>Earl Hill 756 Scarsdale Circle, Lancaster PA   |               |   |  |  |  |                               |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease</u><br>4029<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>3 days</u> |  |  |  |  |               |   |  |  |  |                               |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>None</u>  |  |  |  |  |               |   |  |  |  |                               |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |               | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |               |   |  |  |  |                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |               |   |  |  |  |                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March 11, 1988</u> to <u>Nov 19, 1980</u> , that (I) (we) last saw the deceased alive on <u>Nov 19, 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.  |  |  |  |  |               |   |  |  |  |                               |  |
| 22b. SIGNATURE<br><u>William R. Law, M.D.</u>  |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                 |               |   |  | 22c. DATE SIGNED<br>12-1-80  |  |                               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>WILLIAM R. LAW, M.D.  |  | 22e. ADDRESS<br>2050 W. BALTIMORE ST   |  |  |               |   |  |  |  |                               |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>12/3/80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mount Auburn Cemetery  |               | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore MD                                      |  |  |  |                               |  |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br>Wm. C. March F/H 1101 E. North Ave.   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 2 1980  |               | 25b. REGISTRAR'S SIGNATURE<br><u>Patricia Kennedy</u>   |  |  |  |                               |  |

TO HOSPITAL ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 1 5 9

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|  |  |  |   |  |                            |   |
|--|--|--|---|--|----------------------------|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Laura B. Hill</i>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>11 3 80</i> |  | 2b. HOUR<br><i>4:45 AM</i> |   |
| 3. SEX<br><i>F</i>   |  | 4. RACE<br><i>B</i>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>5 5 08</i>  |                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><i>72</i>  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Id.</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.   |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Baltimore City Hosp.</i> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |                            | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. STATE<br><i>Md</i>  |  | 13b. COUNTY<br><i>Baltimore</i>  |   | 13c. CITY OR TOWN<br><i>Baltimore</i>  |                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Marcus Hill</i>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Mollie Brown</i>   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><i>No</i>  |                            | 16b. SOCIAL SECURITY NO.<br><i>218-03-6272</i>  |
| 17. INFORMANT<br><i>Laura Newsome</i>  |  | 17. ADDRESS<br><i>1722 N. Broadway</i>   |   | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardio-pulmonary arrest</i><br><i>1539</i><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <i>metastatic colon carcinoma</i><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) |                            | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |   |  |                            |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                            | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <i>19</i>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                            |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                            |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>10/31/80</i> to <i>11/13/80</i> , that (I) (we) last saw the deceased alive on <i>11/3/80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. |  |  |   |  |                            |   |
| 22b. SIGNATURE<br><i>C. Krause MD</i>  |  | DEGREE<br><i>MD</i>  |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>   |                            | 22c. DATE SIGNED<br><i>11/13/80</i>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>C. Krause</i>  |  | 22e. ADDRESS<br><i>Balto. City Hospital</i>  |   |  |                            |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>  |  | 23b. DATE<br><i>11/7/80</i>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Mt. Calvary Cemetery</i>  |                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Anne Arundel Co., Md.</i>  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Wm C March F/H</i>  |  | ADDRESS<br><i>1101 E. North Ave.</i>   |   | 25a. DATE REC'D. BY REGISTRAR<br><i>NOV 5 1980</i>   |                            | 25b. REGISTRAR'S SIGNATURE<br><i>History McQuay</i>   |

MEDICAL CERTIFICATION

2  
9

1

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 1 6 0

FOR  
STATE  
REGISTRAR

REG. NO.

|  |   |   |  |  |   |
|--|---|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Nettie A. Hill</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 10 80</b>                             |  | 2b. HOUR<br>M<br><b>M</b>   |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>Black</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Jan. 6 1899</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balto., Md.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>yes USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>               |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore, City</b> MD.                       |   |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>543 W. Lafayette Ave.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>retired</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. STATE<br><b>Md.</b>   |   |   | 13b. COUNTY<br><b>U.S.</b>   | 13c. CITY OR TOWN<br><b>Balto.</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George E. Cornish</b>   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Sarah Cornish</b>              |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>217-20-7982</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Esther Middleton 543 W. Lafayette Ave.</b>                |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute mitral Cerebrovascular Accident</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>S/P Permanent Cardiac problem</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>1978</b> |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>9/29/80</b>                                  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Urinary Tract Infection</b>   |   |   |  |  |   |
| 19a. DATE OF OPERATION<br><b>9/29</b>  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Urinary Tract Infection</b>  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>     |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>11/10/80</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)           |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WORK <input checked="" type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>2300 Garrison Ave. BALTO Md.</b> |   |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>4/5 1980</b> to <b>11/10/80</b> , that (I) (we) last saw the deceased alive on <b>4/5 1980</b> , and that in (my) (our) opinion death occurred on these date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.   |   |   |  |  |   |
| 22b. SIGNATURE<br><b>Eliaht SAUNDERS</b>   |   | DEGREE<br><b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input type="checkbox"/> |  | 22c. DATE SIGNED   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Eliaht SAUNDERS</b>  |   | 22e. ADDRESS<br><b>2300 Garrison Ave.</b>   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |   | 23b. DATE<br><b>11-15-80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ARBUTUS PARK BALTO Md.</b>                      |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leroy O. Dyett</b>  |   | ADDRESS<br><b>4600 Liberty Heights Ave.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 12 1980</b>                                      |   |
|  |   |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Patricia Kelly</b>                                      |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

After the first of the year 1911  
the first of the year 1911

the first of the year 1911

the first of the year 1911

the first of the year 1911

the first of the year 1911



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80

28161

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |  |  |   |  |   |                                   |  |  |
|---|--|---|---|--|--|---|--|---|-----------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>WILLIAM — WILL</b>   |  |   | 2a. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>23</b> YEAR <b>80</b> |  |  | 2b. HOUR<br><b>10 30</b> M  |  |   |                                   |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Black</b>   |   | 5. DATE OF BIRTH<br>MONTH <b>1</b> DAY <b>11</b> YEAR <b>03</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.                                       |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>                          |                                   | IF UNDER 24 HRS<br>HOURS <b>0</b> MIN. <b>0</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>UNION S.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY of Baltimore</b> MD.                    |  |   |                                   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BONSECOURS HOSP</b> |   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>LONGSHOREMAN</b> |  |   | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |   |  |  |   |  |   |                                   |  |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>2</b>   |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>    |  | 13e. STREET ADDRESS<br><b>1528 Poplar Grove St</b>                        |                                   |  |  |
| 14. FATHER'S NAME<br>FIRST <b>Henry</b> MIDDLE <b>I</b> LAST <b>WILL</b>  |  |   |   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>FRANCES</b> MIDDLE <b>JETER</b> LAST <b>JETER</b>  |  |   |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>no</b>  |  |   |   | 16b. SOCIAL SECURITY NO.<br><b>216-10-3747</b>   |  | 17. INFORMANT<br>ADDRESS <b>Carol J. Zabnis - BONSECOURS HOSP</b>                       |  |   |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST.</b><br><b>4254</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>SEVERE CONGESTIVE CARDIOMYOPATHY</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>ISCHAEMIC HEART DISEASE</b> |  |   |   |  |  |   |  |   |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |  |  |   |  |   |                                   |  |  |
| 19a. DATE OF OPERATION  |  |   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)          |  |   |                                   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                       |  |   |                                   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |   |   |  |  |   |  |   |                                   |  |  |
| 22b. SIGNATURE<br><b>Daliah Shamsuddin</b><br>DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |   |   |  |  |   |  | 22c. DATE SIGNED<br><b>11/24/80</b>                                       |                                   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DALIAH SHAMSUDDIN</b>   |  |   |   |  |  | 22e. ADDRESS  |  |   |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>  |  |   |   | 23b. DATE<br><b>11/25/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MAHARRAM</b>                                   |  | 23d. LOCATION<br>CITY OR TOWN <b>BALTIMORE</b> COUNTY <b>MD</b> STATE     |                                   |  |  |
| 24. FUNERAL DIRECTOR<br><b>Mr. Nayan C. 382, C. 1st Ave N</b><br>ADDRESS  |  |   |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 25 1980</b>                                     |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                          |                                   |  |  |

MEDICAL CERTIFICATION



*Handwritten signature or initials.*

NOV 2 2 1960



DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17  
(VRA 15 ME (5))  
15M 7/76

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                         |  |   |  |  |  |   |  | REG. NO. 28162   |  |   |  |
|--|--|-------------------------|--|---|--|--|--|---|--|--|--|---|--|
| 1. STATE REGISTRAR   |  |                         |  |   |  |  |  |   |  |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Charlotte F. Hils</b>   |  |                         |  |   |  |  |  |   |  | 2a. DATE KNOWN OF DEATH ESTI-MATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>11 11 80</b> |  | 2b. HOUR<br><b>1:29 PM</b>  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b> |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>10-8-1905</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>75</b>  |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN.   |  | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR<br><b>11 11 80</b>   |  | 24. HOUR<br><b>1:29 PM</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balto. Md.</b>   |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City,</b> MD.                                       |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>6216 Ridgeview Avenue</b> |  |  |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Home Maker</b>                       |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                         |  |   |  |  |  |   |  |  |  |   |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY             |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>6216 Ridgeview Ave.-21206</b>   |  |  |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Albert Herrmann</b>  |  |                         |  |   |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Elisabeth Krause</b>                                    |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br><b>No</b>  |  |                         |  | 16b. SOCIAL SECURITY NO.<br><b>212-52-7086</b>  |  |  |  | 17. INFORMANT ADDRESS<br><b>Mr. Andrew Hils - 6216 Ridgeview Ave. 21206</b>   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>Arteriosclerotic Cardiovascular Disease</b><br>IMMEDIATE CAUSE (a) <b>429.2</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF                        |  |                         |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                         |  |   |  |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                         |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                         |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                         |  |   |  |  |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE<br>  |  |                         |  | TITLE (SPECIFY)<br><b>Deputy Chief</b><br>MEDICAL EXAMINER  |  |  |  |   |  | DATE SIGNED<br><b>11/12/80</b>   |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Thomas D. Smith, M.D.</b>  |  |                         |  | ADDRESS<br><b>111 Penn Street</b>   |  |  |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Entombment</b>   |  |                         |  | 23b. DATE<br><b>11-14-80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Park</b>                                   |  |   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b>   |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>John C. Miller Inc-6415 Belair Road</b>  |  |                         |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 17 1980</b>  |  |   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br> |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |   |  | 8 0 2 8 1 6 3  |  |
|---|--|---|--|---|--|--|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO.  |  |   |  |  |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>PERCIE W. HINKLE</b>   |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 28 80</b>                               |  | 2b. HOUR<br><b>7:40 P.M.</b>  |  |  |  |
| 3. SEX<br><b>M</b>  |  | 4. RACE<br><b>✓ C</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 10 04</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b> YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                |  |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>W. Va.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. CITY</b> MD.                       |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSP.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>CARPENTER</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>RETIRED</b>   |  |  |  |
| 13a. STATE<br><b>MD.</b>  |  |   |  | 13b. COUNTY<br><b>BALTO.</b>  |  | 13c. CITY OR TOWN<br><b>BALTO.</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>BENJ. F. HINKLE</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>LUELLA MCCALEY</b>  |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>235-16-0715</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>JOAN KNIGHT 24 VILLAGE RD. 21208</b>                  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PNEUMONIA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 WEEK</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>CHRONIC OBSTRUCTIVE LUNG DISEASE, CANCER - PRIMARY SITE UNKNOWN</b>   |  |   |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/28 19 80</b> to <b>11/28 19 80</b> , that (I) (we) lost the deceased alive on <b>11/28 19 80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)                       |  |   |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>William S. Wood</b>  |  |   |  | DEGREE  |  |  |  | 22c. DATE SIGNED<br><b>11/28/80</b>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>WM S. WOOD M.D.</b>   |  |   |  | 22e. ADDRESS<br><b>SINAI HOSPITAL OF BALTIMORE</b>  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  |   |  | 23b. DATE<br><b>12-2-80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GRACE UN. CH. OF CRIST</b>                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. CITY MD.</b>                            |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>NEWELL F.H.</b>  |  |   |  | ADDRESS<br><b>1100 REISTERS TOWN RD.</b>  |  |  |  | DEPT. OF HEALTH AND MENTAL HYGIENE<br>BALTIMORE, MARYLAND                                       |  |  |  |



M

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1-  
STATE  
REGISTRAR

|  |  |  |   |  |  |   |  |  |  |  |  |   |  |  |
|--|--|--|---|--|--|---|--|--|--|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  | 2a. DATE KNOWN OF DEATH                                     |  |  | 2b. DATE KNOWN OF DEATH   |  |  | 2c. DATE PRONOUNCED DEAD   |  |  | 2d. HOUR                                  |  |  |
| FIRST<br>JOHN  |  |  | MIDDLE<br>M.  |  |  | LAST<br>HIOTIS  |  |  | MONTH<br>11  |  |  | DAY<br>12                                 |  |  |
| YEAR<br>1980   |  |  | MONTH<br>11   |  |  | DAY<br>12   |  |  | YEAR<br>1980   |  |  | HOUR<br>9:50                              |  |  |
| 3 SEX<br>male  |  |  | 4 RACE<br>white   |  |  | 5. DATE OF BIRTH  |  |  | 6. AGE (IN YEARS)  |  |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) |  |  |
| MONTH<br>2   |  |  | DAY<br>22   |  |  | YEAR<br>28  |  |  | LAST BIRTHDAY<br>52 YRS.   |  |  | Greece                                    |  |  |
| 7b. CITIZEN OF WHAT COUNTRY?   |  |  | 8. MARRIED  |  |  | IF UNDER 1 YR.  |  |  | IF UNDER 24 HRS.   |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH      |  |  |
| Greece   |  |  | WIDOWED   |  |  | NEVER MARRIED   |  |  | MONTHS   |  |  | Baltimore City                            |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION    |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  | 13a. STREET ADDRESS                       |  |  |
| Baltimore  |  |  | Johns Hopkins Hospital                                      |  |  | Restaurateur  |  |  | Food   |  |  | 619 S. Newkirk Street                     |  |  |
| 13a. STATE   |  |  | 13b. COUNTY   |  |  | 13c. CITY OR TOWN   |  |  | 13d. INSIDE CITY LIMITS?   |  |  | 13e. STREET ADDRESS                       |  |  |
| Maryland   |  |  |   |  |  | Baltimore   |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                  |  |  | 619 S. Newkirk Street                     |  |  |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME                                    |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?                                  |  |  | 16b. SOCIAL SECURITY NO.   |  |  | 17. INFORMANT ADDRESS                     |  |  |
| FIRST<br>Michael   |  |  | MIDDLE<br>Hiotis  |  |  | LAST<br>Evgenia   |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/> (IF YES, GIVE WAR OR DATES) |  |  | 218-64-4825                               |  |  |
| Kasiani Hiotis, 619 S. Newkirk Street  |  |  | Baltimore, Md.  |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)     |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |   |  |  |
| PART 1 DEATH WAS CAUSED BY:  |  |  | IMMEDIATE CAUSE (a)   |  |  | DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |   |  |  |
| 9651   |  |  | Shotgun & gunshot wounds of chest & abdomen                 |  |  |   |  |  |  |  |  |   |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |  |  | (b)   |  |  | DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |   |  |  |
| (c)  |  |  |   |  |  |   |  |  |  |  |  |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.  |  |  |   |  |  |   |  |  |  |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |  | 20. AUTOPSY?  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                  |  |  |   |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |  | 21b. TIME OF INJURY   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |  |  |  |  |   |  |  |
| 9 P.M. 11-12-80  |  |  | Subject shot.   |  |  |   |  |  |  |  |  |   |  |  |
| 21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  |  | 21f. LOCATION   |  |  | CITY OR TOWN   |  |  | STATE                                     |  |  |
| bldg.  |  |  | 891 Greenmount Ave., Balto.                                 |  |  |   |  |  |  |  |  | Md.                                       |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |  |   |  |  |   |  |  |  |  |  |   |  |  |
| ACTUAL SIGNATURE   |  |  | TITLE (SPECIFY)   |  |  | DATE SIGNED   |  |  | 11-13-80   |  |  |   |  |  |
| Ann M. Dixon, M.D.   |  |  | M.D. Assistant  |  |  | MEDICAL EXAMINER  |  |  |  |  |  |   |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |  |  | ADDRESS   |  |  | 111 Penn St.  |  |  |  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  | 23b. DATE   |  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |  | 23d. LOCATION  |  |  | COUNTY                                    |  |  |
| Burial   |  |  | 11-15-80  |  |  | Oak Lawn Cemetery   |  |  | Baltimore  |  |  | Baltimore Md.                             |  |  |
| 24. FUNERAL DIRECTOR   |  |  | 25a. DATE REC'D. BY REGISTRAR                               |  |  | 25b. REG. NO.   |  |  |  |  |  |   |  |  |
| Nicholas T. Matthews, 3029 Eastern Avenue  |  |  | NOV 17 1980   |  |  |   |  |  |  |  |  |   |  |  |
| Baltimore, Md.   |  |  |   |  |  |   |  |  |  |  |  |   |  |  |

(M)



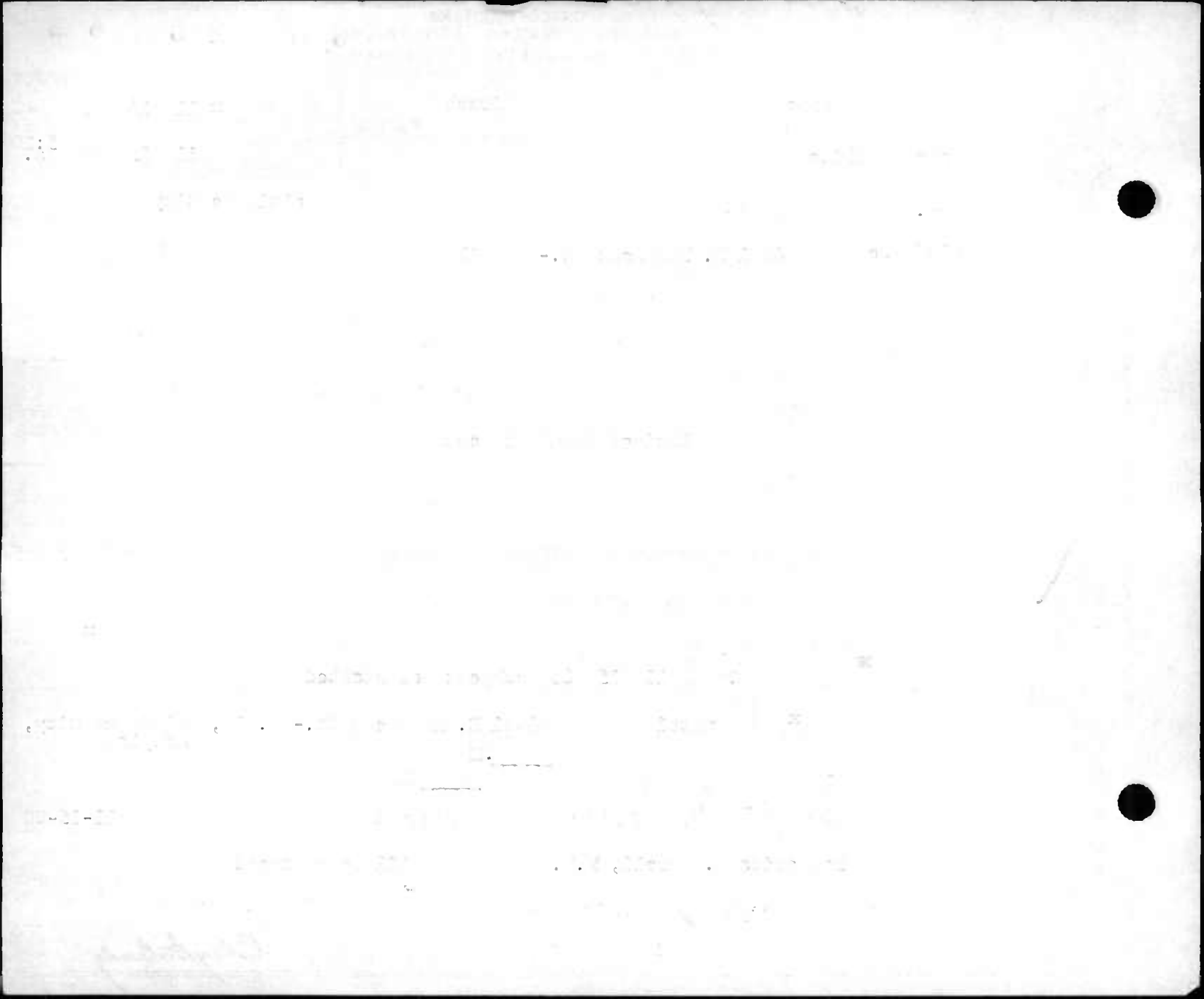


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |         |   |                   |  |                  |
|---|---------|---|-------------------|--|------------------|
| 1. FOR STATE REGISTRAR  |         | 2a. DATE KNOWN OF DEATH   |                   | 2b. HOUR   |                  |
| 1. DECEASED NAME (TYPE OR PRINT)  |         | 2a. DATE KNOWN OF DEATH   |                   | 2b. HOUR   |                  |
| Donna M Hirsch  |         | 11 14 1980  |                   | M  |                  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH  | 6. AGE (IN YEARS) | IF UNDER 1 YR.   | IF UNDER 24 HRS. |
| Female  | White   | August 3, 1960  | 20 YRS.           | MONTHS   | DAYS             |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?  |                   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                  |
| Maryland  |         | U.S.A.  |                   | 9. BALTIMORE CITY OR COUNTY OF DEATH   |                  |
| Baltimore   |         | 4601 E. Monument St.-Room 17  |                   | Baltimore City MD  |                  |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |                  |
| Baltimore   |         | 4601 E. Monument St.-Room 17  |                   | Waitress   |                  |
| 13a. STATE  |         | 13b. COUNTY   |                   | 13c. CITY OR TOWN  |                  |
| Maryland  |         |   |                   | Baltimore  |                  |
| 14. FATHER'S NAME   |         | 15. MOTHER'S MAIDEN NAME  |                   | 13d. INSIDE (CITY LIMITS?)   |                  |
| Robert L Hirsch   |         | Glenda M Wilt   |                   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)  |         | 16b. SOCIAL SECURITY NO.  |                   | 17. INFORMANT ADDRESS  |                  |
| No  |         |   |                   | Mrs Glenda M Hirsch Same   |                  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |         |   |                   |  |                  |
| PART I DEATH WAS CAUSED BY: <u>Incised Wound of Neck</u>  |         |   |                   |  |                  |
| IMMEDIATE CAUSE (a) <u>9660</u>   |         |   |                   |  |                  |
| DUE TO, OR AS A CONSEQUENCE OF  |         |   |                   |  |                  |
| Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last.</u>  |         |   |                   |  |                  |
| (b) _____   |         |   |                   |  |                  |
| DUE TO, OR AS A CONSEQUENCE OF  |         |   |                   |  |                  |
| (c) _____   |         |   |                   |  |                  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |         |   |                   |  |                  |
| 19a. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |                   | 20. AUTOPSY?   |                  |
|   |         |   |                   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         | 21b. TIME OF INJURY   |                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |                  |
|   |         | ? P.M. 11 15 1980   |                   | subject was stabbed  |                  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK   |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |                   | 21f. LOCATION  |                  |
|   |         | motel   |                   | 4601 E. Monument St.-Rm. 17, Baltimore City, Maryland  |                  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |   |                   |  |                  |
| ACTUAL SIGNATURE  |         | TITLE (SPECIFY)   |                   | DATE SIGNED  |                  |
| Margarita A. Korell, M.D.   |         | Assistant   |                   | 11-15-80   |                  |
| EXAMINER'S NAME (TYPE OR PRINT)   |         | ADDRESS   |                   |  |                  |
| Margarita A. Korell, M.D.   |         | 111 Penn Street   |                   |  |                  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |         | 23b. DATE   |                   | 23c. NAME OF CEMETERY OR CREMATORY   |                  |
| Burial  |         | 11/19/80  |                   | Holy REdeemer  |                  |
| 23d. LOCATION (CITY OR TOWN)  |         | 23e. DATE REC'D. BY REGISTRAR   |                   | 23f. REGISTRAR'S SIGNATURE   |                  |
| Baltimore, Maryland   |         | NOV 18 1980   |                   | [Signature]  |                  |
| 24. FUNERAL DIRECTOR  |         | 25a. DATE REC'D. BY REGISTRAR   |                   | 25b. REGISTRAR'S SIGNATURE   |                  |
| Leonard J Ruck Inc. Baltimore, Maryland   |         | NOV 18 1980   |                   | [Signature]  |                  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |   |  |  |  |  |  |   |  |  |
|--|--|--|---|--|--|--|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ISABELLA M. HISKY</b>   |  |  | 2a. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>10</b> YEAR <b>80</b>                       |  |  | 2b. HOUR<br><b>2:15 PM</b>   |  |  |   |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH <b>April</b> DAY <b>1</b> YEAR <b>1894</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b> YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b> |   |  |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 9. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>  |   | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 11. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD  |  |  |   |  |  |
| 12. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b> |   |  |  | 14. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>  |  | 15. KIND OF BUSINESS OR INDUSTRY   |   |  |  |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>16a. STATE <b>Maryland</b>  |  |  | 16b. CITY OR TOWN <b>Baltimore</b>  |  |  | 16c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 16d. STREET ADDRESS<br><b>1 N. Rolling Road</b>   |  |  |
| 17. FATHER'S NAME<br>FIRST <b>Thomas</b> MIDDLE <b>F.</b> LAST <b>Hisky</b>  |  |  | 18. MOTHER'S MAIDEN NAME<br>FIRST <b>Hannah</b> MIDDLE <b>T.</b> LAST <b>McClelland</b> |  |  |  |  |  |   |  |  |
| 19. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>no</b>  |  |  | 20. SOCIAL SECURITY NO.<br><b>220-44-1843J</b>  |  |  | 21. INFORMANT<br><b>Helen T. Hisky</b>   |  |  | 22. ADDRESS<br><b>1 N. Rolling Road, 21228</b>  |  |  |
| 23. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Ventricular arrhythmia</b><br><b>5860</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Digitalis toxicity, Heart block</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Unlabeled Failure</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |   |  |  |  |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Sepsis, ASCVD</b>  |  |  |   |  |  |  |  |  |   |  |  |
| 24. DATE OF OPERATION<br><b>9/19/80</b>  |  |  | 25. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 26. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  | 27. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 28. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 29. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>                        |  |  | 30. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |   |  |  |
| 31. INJURY OCCURRED<br>AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 32. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                   |  |  | 33. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |  |
| 34. I certify that (I) (this hospital) attended the deceased from <b>Oct 20</b> 19 <b>80</b> , to <b>Nov 10</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>Nov 10</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |   |  |  |  |  |  |   |  |  |
| 35. SIGNATURE<br><b>Otto Hernandez</b>   |  |  | 36. DEGREE<br><b>M.D.</b>   |  |  | 37. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  | 38. DATE SIGNED<br><b>11-16-80</b>  |  |  |
| 39. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>OTTO HERNANDEZ</b>  |  |  | 40. ADDRESS   |  |  |  |  |  |   |  |  |
| 41. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>  |  |  | 42. DATE<br><b>11/13/80</b>   |  |  | 43. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral Cem.</b>   |  |  | 44. LOCATION<br>CITY OR TOWN <b>Baltimore</b> COUNTY <b>Maryland</b> STATE  |  |  |
| 45. FUNERAL DIRECTOR NAME<br><b>Witzke Funeral Home of Catonsville, P.A. 21228</b>   |  |  |   |  |  | 46. ADDRESS<br><b>1630 Edmondson Ave., Catonsville, Md</b>   |  |  | 47. DATE REC'D. BY REGISTRAR<br><b>NOV 13 1980</b>  |  |  |
|  |  |  |   |  |  | 48. REGISTRAR'S SIGNATURE<br><b>Helen T. Hisky</b>   |  |  |   |  |  |

1. *Handwritten text, likely a list or notes.*

10. 10. 10

*Handwritten signature or name.*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 1 6 7

REG. NO.

|   |  |  |  |  |                                 |  |
|---|--|--|--|--|---------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Mildred Pearl Hoffman   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 10, 1980 |  | 2b. HOUR<br>11:35P <sub>M</sub> |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 11 99  |                                 |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>81   |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |                                 |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |  |                                 |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Maryland General Hospital                   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                        |                                 |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br>-  |  | 13a. STREET ADDRESS<br>515 S. Curley Street  |  |  |                                 |  |
| 13b. COUNTY<br>Maryland   |  | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>      |                                 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Elmer McConkey  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mildred Langford  |  |  |                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>213-74-1706   |  | 17. INFORMANT<br>ADDRESS<br>Mrs. Elizabeth M. Langford<br>1912 Woodbourne Road, Baltimore, Md. 21239 |                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY: Anoxic Encephalopathy<br>IMMEDIATE CAUSE (a) 3481<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____                         |  |  |  |  |                                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br>Diabetes Mellitus; status-post Cardiorespiratory Arrest   |  |  |  |  |                                 |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                            |                                 |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  |  |                                 |  |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |                                 |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                                 |  |
| 22a. I certify that <del>he</del> (this hospital) attended the deceased from November 3, 1980, to November 10, 1980, that <del>he</del> (we) lost saw the deceased alive on November 10, 1980, and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>so</del> (we) (did) <del>not</del> view the body after death. |  |  |  |  |                                 |  |
| 22b. SIGNATURE<br>Eugenio Machado   |  | DEGREE<br>MD   |  | 22c. DATE SIGNED   |                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Eugenio Machado, M.D.  |  | 22e. ADDRESS<br>C/O Maryland General Hospital  |  |  |                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>11-14-80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood Cemetery  |                                 |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Baltimore Md.   |  | 24. FUNERAL DIRECTOR<br>Nicholas T. Matthews, 3021 Eastern Ave., Balto.  |  |  |                                 |  |
| 25a. DATE REC'D. BY REGISTRAR<br>NOV 17 1980  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |  |                                 |  |

MEDICAL CERTIFICATION

0701 BP 5



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 1 6 8

FOR  
STATE  
REGISTRAR

REG. NO.

|  |   |   |   |  |  |
|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>THOMAS F. HOLDEN, JR</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>NOVEMBER 20, 1980</b>                                    |  | 2b. HOUR<br><b>3:45 A.M.</b>                                       |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>WHITE</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>JULY 16, 1918</b>   |   | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>62</b>                                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BALTO., Md</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD                     |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>5301 BARBARA AVE.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>CAPTAIN</b>              |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>BALTO. CITY FIRE DEPT.</b> |
| 13a. STATE<br><b>Md.</b>   | 13b. COUNTY<br><b>—</b>   | 13c. CITY OR TOWN<br><b>BALTO.</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>5301 BARBARA AVE</b>                                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>THOMAS HOLDEN, SR</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>SARAH McDERMOTT</b>   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>YES</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>W.W. 11 215-10-7821</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>MRS. MARY HOLDEN 5301 BARBARA AVE</b>                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiopulmonary arrest</b><br><b>1629</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>widely metastatic large cell undifferentiated 1 year</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>carcinoma of the lung</b> |   |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |   |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>July</b> , 19 <b>80</b> , to <b>November 20</b> , 19 <b>80</b> , that (I) (we) lost<br>saw the deceased alive on <b>November 4</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above; (I) (we) did not view the body after death.  |   |   |   |  |  |
| 22b. SIGNATURE<br><b>Aron Berkman</b>  |   | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>11/21/80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Aron Berkman</b>   |   | 22e. ADDRESS<br><b>Johns Hopkins Oncology Center</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  | 23b. DATE<br><b>11-24-1980</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>NEW CATHEDRAL</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. Md.</b>                      |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>J. Walter Gerblin 5444 BELAIR RD.</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 24 1980</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                     |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



*[Faint, illegible text, likely bleed-through from the reverse side of the page.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 31 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 28169

|  |   |   |  |  |                                   |   |  |                        |  |
|--|---|---|--|--|-----------------------------------|---|--|------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |   | FIRST MIDDLE LAST   |  | 2a. DATE OF DEATH  |                                   | MONTH DAY YEAR  |  | 2b. HOUR               |  |
| WILLIAM HENRY HOLLAND  |   |   |  | 11 21 80   |                                   |   |  | 2:35A M                |  |
| 3. SEX   | 4. RACE   | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |                                   | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS        |  |
| MALE   | BLACK   | MONTH DAY YEAR<br>5 11 156  |  | 65 YRS   |                                   | MONTHS DAYS   |  | HOURS MIN              |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |                                   |   |  |                        |  |
| MARYLAND   | U.S. A.   |   |  | BALTIMORE CITY MD.   |                                   |   |  |                        |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY |   |  |                        |  |
| BALTIMORE  | VAMC LOCH RAVEN, BALTIMORE, MD  |   |  |  |                                   |   |  |                        |  |
| 13a. STATE   |   | 13b. COUNTY   |  | 13c. CITY OR TOWN  |                                   | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS    |  |
| MARYLAND   |   |   |  | BALTIMORE  |                                   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 1727 Old Frederick Rd. |  |
| 14. FATHER'S NAME  |   | 15. MOTHER'S MAIDEN NAME  |  |  |                                   |   |  |                        |  |
| FIRST MIDDLE LAST  |   | FIRST MIDDLE LAST   |  |  |                                   |   |  |                        |  |
|  |   | Elizabeth Holland   |  |  |                                   |   |  |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |   | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS  |                                   |   |  |                        |  |
| YES  |   | WW II   |  | Helen J. Holland 931 Cherryhill Rd.  |                                   |   |  |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY.   |   | IMMEDIATE CAUSE (a)   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                   |                                   |   |  |                        |  |
| 4149   |   | Bronchopneumonia  |  | Weeks  |                                   |   |  |                        |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |   | (b)   |  | years  |                                   |   |  |                        |  |
|  |   | Chronic heart failure   |  |  |                                   |   |  |                        |  |
|  |   | (c)   |  | years  |                                   |   |  |                        |  |
|  |   | Coronary artery disease   |  |  |                                   |   |  |                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |   |   |  |  |                                   |   |  |                        |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?  |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |                        |  |
|  |   |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |                                   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                   |   |  |                        |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                   |   |  |                        |  |
|  |   |   |  |  |                                   |   |  |                        |  |
| 22a. I certify that (this hospital) attended the deceased from AUGUST 26 19 80, to NOVEMBER 21 19 80, that (we) last saw the deceased alive on NOVEMBER 21 19 80, and that in (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. |   |   |  |  |                                   |   |  |                        |  |
| 22b. SIGNATURE   |   | DEGREE  |  | 22c. DATE SIGNED   |                                   |   |  |                        |  |
| Margaret Kaiser MD   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |  | 11/21/80   |                                   |   |  |                        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |   | 22e. ADDRESS  |  |  |                                   |   |  |                        |  |
| KAISER   |   | 3900 LOCH RAVEN BLVD, BALTIMORE, MD 21218   |  |  |                                   |   |  |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |   | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |                                   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |                        |  |
| Burial   |   | 11/26/80  |  | Cheltenham VA Cem.   |                                   | Cheltenham MD   |  |                        |  |
| 24. FUNERAL DIRECTOR<br>NAME   |   | ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR  |                                   | 25b. REGISTRAR'S SIGNATURE  |  |                        |  |
| Wm. C. March F/H   |   | 1101 E. North Ave.  |  | NOV 25 1980  |                                   | [Signature]   |  |                        |  |



0891 22 V04

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

2 8 1 7 0

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |   |  |   |  |  |  |  |   |  |
|--|--|---|--|---|---|--|---|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>George J. Holmes  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 8, 1980                |   | 2b. HOUR<br>8:30 AM   |  |   |  |  |  |  |   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>April 30, 1903  |   | 6. AGE (IN YEARS, LAST BIRTHDAY)<br>77 YRS.                                      |   | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.               |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                       |   |  |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3515 Falls Rd. |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Ret. Foreman |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Balto. City   |  |  |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  |   | 13b. COUNTY  |   | 13c. CITY OR TOWN<br>Baltimore                              |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>3515 Falls Rd.        |  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George J. Holmes, Sr.  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Unknown               |   |   |  |   |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>219-07-4190A   |  | 17. INFORMANT<br>ADDRESS<br>George Mooney, 5 Bexliegh Ct. 21234   |   |  |   |  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Sick-Sinus Syndrome. Pacemaker</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |   |  |   |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>        |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                |   |  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7</u> 19 <u>80</u> , to <u>11/8</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>11/5</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |  |   |   |  |   |  |  |  |  |   |  |
| 22b. SIGNATURE<br><u>Benjamin K. Yorkoff, M.D.</u><br>DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |   |  |   |   | 22c. DATE SIGNED<br>11/10/80   |   |  |  |  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Benjamin Yorkoff, M.D.  |  |   |  |   |   | 22e. ADDRESS<br>7401 Osler Drive   |   |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation   |  |   | 23b. DATE<br>11-10-80  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Crematory |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland   |  |  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Ruck Towson Funeral Home, Inc.   |  |   |  |   |   | ADDRESS<br>1050 York Rd.<br>Towson, Md. 21204                                    |   |  | 25a. DATE REG'D. BY REGISTRAR<br>NOV 12 1980 |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Anthony McCready</u> |  |

10-1-1947

Dear Sir,

I have the pleasure to acknowledge the receipt of your letter of the 28th inst. in relation to the above matter.

The same has been referred to the appropriate authorities for their consideration.

I am, Sir, very respectfully,  
Yours faithfully,  
[Signature]

[Name]  
[Title]

RECEIVED

10-1-1947

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.


 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

8 0 2 8 1 7 1

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |   |  |  |  |
|--|--|--|---|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Murray Holmes</i>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>11/2/80</i>   |  | 2b. HOUR<br><i>6:12 PM</i>                                       |  |
| 3 SEX<br><i>male</i>   | 4 RACE<br><i>W</i>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>10 27 1905</i>                |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>YRS MONTHS DAYS<br><i>75</i>                               |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>South Carolina</i>   | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City MD</i> |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Provident Hospital</i> |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Factory Worker</i>    |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br><i>MARYLAND</i>  |  | 13c. CITY OR TOWN<br><i>Baltimore</i>                                  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Charlie Holmes</i>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Flossie</i>        |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>166-22-6619</i>                         |   | 17. INFORMANT<br>ADDRESS<br><i>Jacey Holmes 2214 Baker Street</i>                            |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <i>Cardio pulmonary arrest</i><br><i>4100</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <i>Myocardial Infarction</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>Atherosclerotic heart disease</i> |  |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                    |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)               |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>11-2</i> , 19 <i>80</i> , to <i>11-2</i> , 19 <i>80</i> , that (I) (we) lost saw the deceased alive on <i>11-2</i> , 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><i>James Benson Hunt MD</i>  |  | DEGREE   |   | 22c. DATE SIGNED<br><i>11/3/80</i>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>James Benson Hunt MD</i>   |  | 22e. ADDRESS<br><i>Provident Hosp. ER</i>                              |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>BURIAL</i>  | 23b. DATE<br><i>11/8/80</i>  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>MT Auburn Cem</i>             |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Baltimore Maryland</i>                      |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Wm C. Brown Comm F.H.</i>   |  | ADDRESS<br><i>1206-08 W. North Ave</i>                                 |   | 25a. DATE REC'D. BY REGISTRAR<br><i>NOV 10 1980</i>  |  |  |
|  |  |  |   | 25b. REGISTRAR'S SIGNATURE<br><i>P. J. Kennedy</i>   |  |  |

100-100000-100000



100-100000-100000

100-100000-100000

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 28172

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|  |   |   |  |  |   |
|--|---|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>JOSEPH W. HOLTZNER, SR.                                    |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11/12/80                            |  | 2b. HOUR<br>4 <sup>10</sup> P.M.  |
| 3. SEX<br>MALE   | 4. RACE<br>WHITE  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 28 18 <sup>r</sup>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>62                                      | 7. UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.            |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                 |  |   |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BON SECOURS HOSPITAL |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>ROOFER | 12b. KIND OF BUSINESS OR INDUSTRY<br>CHARLES F. RUFF |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MARYLAND |   |   | 13b. COUNTY<br>---   | 13c. CITY OR TOWN<br>BALTIMORE                       | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOSEPH HOLTZNER  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE<br>MARGARET HICKSEY               |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WWII   | 17. INFORMANT<br>ADDRESS<br>JOSEPH W. HOLTZNER, JR. 1845 W. LOMBARD ST.   |  |  |   |

|  |  |   |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br>4100 Acute coronary occlusion |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>months |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>Chronic obstructive pulmonary disease   |  | years   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>ASVD. (cardiomyopathy)  |  | years   |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

## MEDICAL CERTIFICATION

|  |  |  |   |
|--|--|--|---|
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |
| 22a. I certify that (I) (this hospital) attended the deceased from July 1980 to Nov. 4/80, that (I) (we) lost<br>saw the deceased alive on Nov. 4, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |   |
| 22b. SIGNATURE<br>Henry Armanas M.D.   | DEGREE<br>M.D.   | 22c. DATE SIGNED<br>Nov 15/80  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>HENRY ARMANAS, M.D.   |  | 22e. ADDRESS<br>1934 WILKENS AVENUE  |   |

|  |                       |   |  |
|--|-----------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL                 | 23b. DATE<br>11/17/80 | 23c. NAME OF CEMETERY OR CREMATORY<br>CREST LAWN CEMETERY | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>MARRIOTTSTVILLE HOWARD MD. |
| 24. FUNERAL DIRECTOR<br>NAME<br>HUBBARD FUNERAL HOME 4107 WILKENS AVE. |                       | 25a. DATE REC'D. BY REGISTRAR<br>NOV 17 1980              | 25b. REGISTRAR'S SIGNATURE<br>L. J. [Signature]                          |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





05/31/00

*[Handwritten signature]*

NOV 17 1900



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or after traumatic event, the medicolegal examiner must be notified at once.

FOR  
1. STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |   |   |   |   |   |
|---|---|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>MAMIE Grey HOOD   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Nov 12 80  |   | 2b. HOUR<br>11:19 AM  |
| 3. SEX<br>female  | 4. RACE<br>white  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Dec. 20, 1909   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>70   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO. CITY MD.   |   |   |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HSPITAL |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Sales lady  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Mont. Ward   |   |
| 13a. STATE<br>MD  |   |   | 13b. COUNTY<br>xx xxx   | 13c. CITY OR TOWN<br>Baltimore  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William H. Smith  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mamie E. Crowder   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>NO   |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>XXXXXXXXXX   | 17. INFORMANT<br>ADDRESS<br>Mr. Robert C. Hood (son) Pasadena, MD   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u><br>2041<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Thrombocytopenia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Chronic Lymphocytic Leukemia</u>   |   |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |   |   |   |   |   |
| 19a. DATE OF OPERATION<br><u>NONE</u>   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |   |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |   |
| 22a. I certify that I (this hospital) attended the deceased from <u>Nov 3</u> , 19 <u>80</u> , to <u>Nov 12</u> , 19 <u>80</u> , that (we) last saw the deceased alive on <u>Nov 12</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |   |   |   |   |   |
| 22b. SIGNATURE<br><u>N. Joseph Gallandi</u>   |   | DEGREE<br><u>MD</u>   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><u>11/12/80</u>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>N. Joseph GALLIANDI MD</u>  |   | 22e. ADDRESS<br><u>Union Memorial Hosp. BALT. MD.</u>   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>Burial</u>   | 23b. DATE<br><u>15 Nov. 80</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Glen Haven Mem Pk.</u>   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Glen Burnie, MD</u>  |   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Singleton Funeral Home</u>   |   | ADDRESS<br><u>Glen Burnie, MD</u>   |   | 25a. DATE REC'D. BY REGISTRAR<br><u>NOV 13 1980</u>   |   |
|   |   |   |   | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

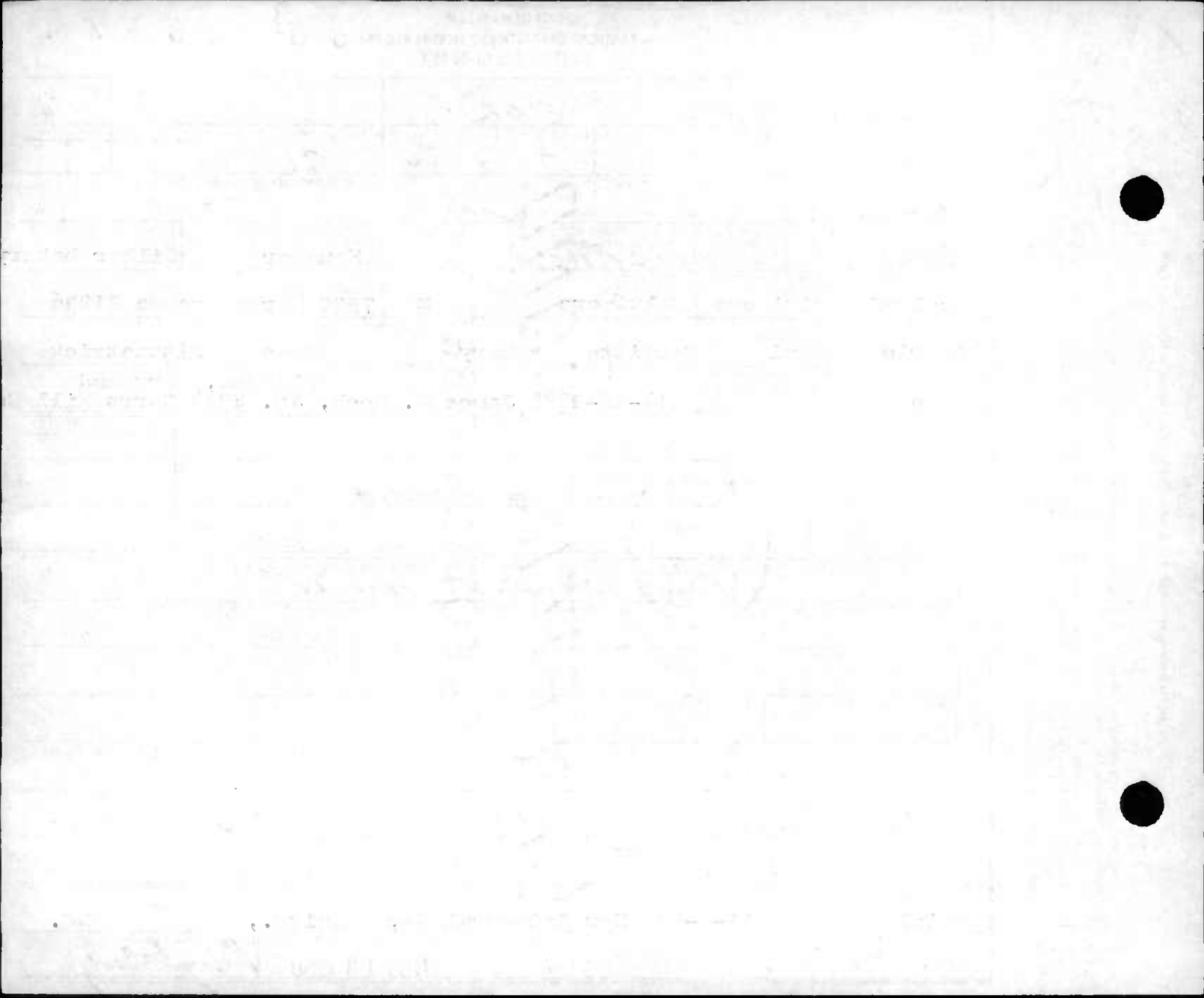
IMPORTANT: If item 21 is marked or item 18 shows any injury, or after traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |   |   |   |  |  |
|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>SALVATORA L HOOK  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 5 80  |  | 2b. HOUR<br>11:20 AM   |
| 3. SEX<br>F  | 4. RACE<br>W  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7 4 09  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS.  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                   |  |
| 8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  | 8b. CITIZEN OF WHAT COUNTRY?<br>US  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>CITY MD.  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALT.   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>MERCY HOSP |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Manager             | 12b. KIND OF BUSINESS OR INDUSTRY<br>Silber bakery                                   |  |
| 13a. STATE<br>Maryland   |   |   | 13b. COUNTY<br>Baltimore  | 13c. CITY OR TOWN<br>Baltimore   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Rosario Paul Fertitta  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Rose Fitzpatrick                  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no   |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>214-30-2884  | 17. INFORMANT<br>ADDRESS<br>Fallston, Maryland<br>James M. Hook, Jr. 2214 Carrs Mill Rd |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u><br><u>4149</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>CARDIAC ANGIOSPLASIA</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>CORONARY ARTERY DISEASE</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>CONGESTIVE HEART FAILURE</u>  |   |   |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)        |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/10/24</u> , 19 <u>80</u> , to <u>11/5</u> , 19 <u>80</u> , that (I/we) lost saw the deceased alive on <u>11/5</u> , 19 <u>80</u> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.   |   |   |   |  |  |
| 22b. SIGNATURE<br><u>R.C. Kungu</u>  |   | DEGREE<br><u>MD</u>   |   | 22c. DATE SIGNED<br><u>11/5/80</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>R.C. KUNZE</u>   |   | 22e. ADDRESS<br><u>Mercy Hosp.</u>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |   | 23b. DATE<br>11-8-80  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>New Cathedral Cem                              |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto., Md.  |   | 23e. DATE REC'D. BY REGISTRAR<br>NOV 13 1980  |   | 23f. REGISTRAR'S SIGNATURE<br><u>Barbara McCreedy</u>                                |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><u>Glenn H. 7401 Belair Rd.</u>  |   |   |   |  |  |



DHMH-16 30M 2/80  
(VRA 15, 4)

R

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filed in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

2 8 1 7 5

REG. NO.

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>GEORGE J HOOPER</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 14 80</b>  |  | 2b. HOUR<br><b>7<sup>20</sup> A M</b>  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept 26, 1919</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>61</b><br>YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Penna.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br><b>Manager Communication System</b>                                    |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br><b>Penna. Harrisburg, Pa</b>  |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles Hoover</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>MIDDLE<br><b>Dotte DeShong</b>                                      |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>204-03-1796</b>   | 17. INFORMANT ADDRESS<br><b>Mrs Shirley R Hoover Same</b>                                       |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>? PULMONARY EMBOLUS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>S/P Arrest, Aortic Valve Replacement, Myocardial 16 days</b>                                 |  |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>1HR</b><br><b>1HR</b>  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>MACROUTION, SEPSIS</b>   |  |   |   |  |  |
| 19a. DATE OF OPERATION<br><b>10/28/80</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Aortic Stenosis</b>  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10-28</b> , 19 <b>80</b> , to <b>11-14</b> , 19 <b>80</b> , that (I) (we) last<br>saw the deceased alive on <b>11-14</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |   |  |  |
| 22b. SIGNATURE<br><b>CHARLES JOHN YEO MD</b>  |  | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>11/14/80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CHARLES JOHN YEO MD</b>   |  | 22e. ADDRESS<br><b>JOHNS HOPKINS HOSPITAL</b>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>11/17/80</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Hustontown Methodist</b>                               |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Hustontown Penna.</b>   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J Ruck Inc. Baltimore, Maryland</b>  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 17 1980</b>   |  |  |

REGISTRAR'S SIGNATURE  
**Robert Ruck**



OFFICE OF THE  
DIRECTOR

2

1913

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 1 7 6

REG. NO.

|  |  |  |  |   |  |  |  |   |  |
|--|--|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>PHYLLIS</b>  |  | MIDDLE<br><b>HOPKINS</b>   |  | LAST<br><b>HOPKINS</b>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 - 11 - 80</b>                           |  | 2b. HOUR<br><b>12:35</b>  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 - 08 - 39</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>41</b> YRS.                                    |  | 2c. UNDER 1 YEAR<br>MONTHS DAYS<br><b>41</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BALTIMORE - MD</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>AMERICAN</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b>                        |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE - MD</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>  |  | 13b. CITY OR TOWN<br><b>BALTIMORE</b>  |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13d. STREET ADDRESS<br><b>APT. D #21209<br/>6505 SANZO ROAD</b>                      |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>THEODORE DUNN</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ANNA SAVITZ</b>   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(IF YES, GIVE WAR OR DATES)<br><b>NO</b>   |  | 17. INFORMANT<br><b>MRS. JUDITH DWORKIN</b>   |  | 17. ADDRESS<br><b>3909 RANDALLSTOWN, MD 21133</b>                                    |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ADENOCARCINOMA OF BREAST</b><br><b>1749</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10 - 17 - 19 80</b> to <b>11 - 11 - 19 80</b> , that (I) (we) lost<br>saw the deceased alive on <b>11 - 10 - 19 80</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Cesar A. Vinuesa</b> M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>  |  |  |  |   |  | 22c. DATE SIGNED<br><b>11-11-80</b>  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CESAR A. VINUEZA</b>   |  |  |  | 22e. ADDRESS<br><b>2300 PINEWOOD AVE</b>  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>NOV. 13, 1980</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BETH JACOB</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>FINKSBURG CARROLL MD</b>            |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b><br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 18 1980</b>                                  |  |   |  |

BP \_\_\_\_\_

DHMH-16 25M  
(VRA 15.4) 1/79

0 1 1 0

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

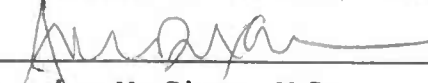

11-11-11

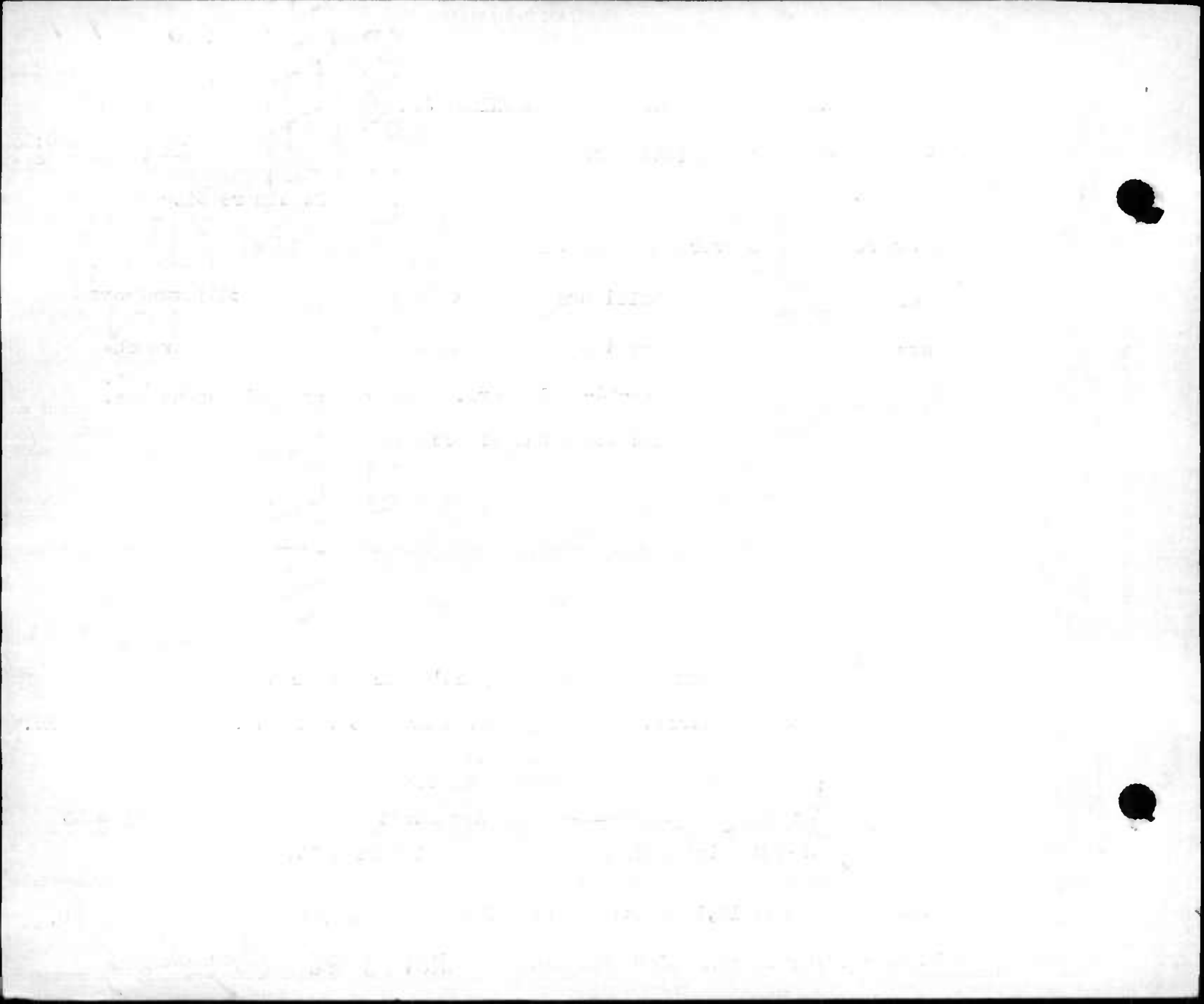
11-11-11



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                  |  |   |  |   |  |   |  | REG. NO. 0 28177  |  |   |  |   |  |
|--|--|------------------|--|---|--|---|--|---|--|---|--|---|--|---|--|
| 1. FOR REGISTRAR   |  |                  |  |   |  |   |  |   |  |   |  |   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>WARE H. HOPKINS, JR.  |  |                  |  |   |  |   |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>MONTH DAY YEAR<br>11 9 80 |  | 2b. HOUR<br>M<br>11 9 80  |  |   |  |
| 3. SEX<br>male   |  | 4. RACE<br>white |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 4 1943  |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>37 YRS.               |  | IF UNDER 1 YR.<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>11 9 80             |  | 2d. HOUR<br>M<br>4:15 a M   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.   |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.        |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>unemployed   |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |
| 13a. STATE<br>Md.  |  |                  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore                                |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br>5651 Purdue Ave                            |  |   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Ware H Hopkins   |  |                  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Inez Strauch |  |   |  |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>NO  |  |                  |  | 16b. SOCIAL SECURITY NO.<br>218-40-8661   |  |   |  | 17. INFORMANT<br>Mrs. Inez Hopkins  |  |   |  | ADDRESS<br>Apt. E<br>5651 Purdue Ave.   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>9660 IMMEDIATE CAUSE (a) Incised wound of neck<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |                  |  |   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.  |  |                  |  |   |  |   |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>? 11-9- 1980   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>Subject's neck was cut.  |  |   |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>  |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>street   |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>1515 N. Charles St., Balto. MD.  |  |   |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                  |  |   |  |   |  |   |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE<br>  |  |                  |  |   |  | TITLE (SPECIFY)<br>Assistant MEDICAL EXAMINER                 |  |   |  | DATE SIGNED<br>11-9-80  |  |   |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Ann M. Dixon, M.D.   |  |                  |  |   |  | ADDRESS<br>111 Penn St.                                       |  |   |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  |                  |  | 23b. DATE<br>NOV. 12, 1980  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>GARDENS OF FAITH        |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MD.       |  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>MITCHELL-WIEDEBOLD HOME  |  |                  |  |   |  | ADDRESS<br>6500 YORK RD.                                      |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 13 1980                      |  |   |  | 25b. REGISTRAR'S SIGNATURE<br> |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 1 7 8

REG. NO.

|   |  |  |  |  |                                       |   |   |  |  |
|---|--|--|--|--|---------------------------------------|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>SAMUEL HORWITZ</b>   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>11-14-80</b>            |  |                                       | 2b. HOUR<br><b>9<sup>40</sup> PM</b>  |   |  |  |
| 3 SEX<br><b>MALE</b>  |  | 4 RACE<br><b>WHITE</b>   |  | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>6 XXX 94</b>  |                                       | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b>   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>RUSSIA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>AMERICAN</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                       | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                      |   |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL</b> |  |  |                                       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>PROPRIETOR</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>DRY CLEANING CO</b>  |  |
| 13a. STATE<br><b>MD</b>   |  |  | 13b. COUNTY<br><b>BALTIMORE</b>                                |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b> |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN HORWITZ</b>   |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b> |  |                                       | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>        |   |  |  |
| 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br><b>216 32 8560</b>  |  |  | 17 INFORMANT<br>ADDRESS<br><b>MISS LILLIAN HORWITZ</b>         |  |                                       | 18. STREET ADDRESS<br><b>3601 FORDS LA. #21215</b>                                    |   |  |  |
| 19. CITY OR TOWN<br><b>BALTO.</b>   |  |  | 20. STATE<br><b>MD</b>   |  |                                       | 21. ZIP CODE<br><b>21215</b>  |   |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PNEUMONIA.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last                |  |  |  |  |                                       |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>CHF.</b>  |  |  |  |  |                                       |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |                                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>             |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                                       |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                                       |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11-13</b> 19 <b>80</b> , to <b>11-14</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>11-14</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |                                       |   |   |  |  |
| 22b. SIGNATURE<br><b>Cesar A. Vinuesa</b>   |  |  |  | DEGREE<br><b>M.D.</b>  |                                       |   |   | 22c. DATE SIGNED<br><b>11-14-80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CESAR A. VINUEZA</b>  |  |  |  | 22e. ADDRESS<br><b>2300 PINWOOD AVE.</b>   |                                       |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>NOV. 16, 1980</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>OHR KNESSETH ISRAEL</b>   |                                       | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ANSHÉ SPARD ROSEDALE BALTO. MD</b>   |   | 24 FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b>   |  |
| 24a. ADDRESS<br><b>6010 REISTERSTOWN RD.</b>  |  | 24b. CITY OR TOWN<br><b>BALTO., MD</b>   |  | 24c. ZIP CODE<br><b>21215</b>  |                                       | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 18 1980</b>                                   |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |

11181

25-1-11

STATION

STATION

17.2

17.2

17.2

17.2

17.2

17.2

17.2

17.2

17.2

17.2

17.2

17.2

17.2

17.2

17.2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 28179

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST MIDDLE LAST (HORWITZ)  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  | 2b. HOUR   |  |
| SAMUEL  |  | M. HORWITZ   |  | 11/27/80  |  | 8:40 P.M.  |  |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | IF UNDER 1 YEAR IF UNDER 24 HRS                                |  |
| Male  | WHITE  | 12 07 1899   |  | 80 YRS  |  | MONTHS DAYS HOURS MIN  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |  |  |
| PA.   | U.S.   |  |  | BALTIMORE CITY MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| BALTIMORE   | LEVINDALE Geriatric Hospital   |  |  | SELF-EMPLOYED   |  | BUTCHER  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  | 13b. INSIDE CITY LIMITS?  |  |  |  |
| 13a. STATE COUNTY   |  |  |  | 13b. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 13a. MARYLAND   |  |  |  | 13b. BALTIMORE  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  | 13c. STREET ADDRESS   |  |  |  |
| ISRAEL HORVITZ  |  | ANNA OSHINSKY  |  | 5811 CLOVER RD. (21215)   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS   |  |  |  |
| YES   |  | 212-01-7431  |  | MRS. MARY HORVITZ   |  |  |  |
|   |  | WWI-ARMY   |  | 5811 CLOVER RD., BALTO., MD   |  | 21215  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |   |  |  |  |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ASPIRATION PNEUMONIA  |  |  |  |   |  |  |  |
| 5939 DUE TO, OR AS A CONSEQUENCE OF (b) RENAL INSUFFICIENCY   |  |  |  |   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |   |  |  |  |
| BICAT HIP FRACTURES: MOUNTAIN   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
|   |  | P.M. 19  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
|   |  |  |  |   |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from 9-17, 19 80, to 11-27, 19 80, that (1) (we) last saw the deceased alive on 11-27, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |
| 22b. SIGNATURE  |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED   |  |
| MARCOZ ROSSCHOR   |  | and  |  |   |  | 11/27/80   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |   |  |  |  |
| MARCOZ ROSSCHOR   |  | COWARTERS HOSS   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                        |  |
| ENTOMBMENT  |  | 11/30/80   |  | OHEB SHALOM MEM. PARK   |  | REISTERSTOWN BALTO. MD   |  |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. NAME ADDRESS  |  |  |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE  |  |  |  |
| 6010 REISTERSTOWN RD. BALTO., MD 21215  |  |  |  | DEC 3 1980 [Signature]  |  |  |  |



62

1892-93

Handwritten signature or text at the bottom left corner.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 28180

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |   |  |   |  |   |  |  |  |  |  |   |  |  |  |  |  |
|--|--|---|--|---|--|---|--|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST MARY  |  | MIDDLE WARD   |  | LAST HOUCK  |  | 2a. DATE OF DEATH  |  | MONTH 11   |  | DAY 03  |  | YEAR 80  |  | 2b. HOUR 10 AM   |  |
| 3. SEX<br>F  |  | 4. RACE<br>W  |  | 5. DATE OF BIRTH<br>MONTH 03 DAY 02 YEAR 1931   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>44 49 YRS.   |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS.   |  | MONTHS  |  | DAYS   |  | HOURS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>North Carolina  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Waitress            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Restaurant  |  | 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore City Hospitals |  | 13a. STATE<br>Maryland   |  |
| 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br>140 S. Patterson Park Ave.   |  | 14. FATHER'S NAME<br>(UNKNOWN)   |  | 15. MOTHER'S MAIDEN NAME<br>(UNKNOWN)  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>no   |  | 16b. SOCIAL SECURITY NO.<br>238-38-7168  |  | 17. INFORMANT<br>Ronald E. Houck, 3831 Ayres Ct. 21236                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u><br>5715<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>PERITONITIS, ASCITES</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>POST NECROTIC CIRRHOSIS</u> |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  | 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                           |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  | 22a. I certify that (this hospital) attended the deceased from <u>8-14-</u> 19 <u>80</u> , to <u>11-3-</u> 19 <u>80</u> , that (we) last saw the deceased alive on <u>11-3-</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE<br>Peter Paul Stamas MD   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>11/3/80   |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>PETER PAUL STAMAS MD  |  | 22e. ADDRESS<br>BCH   |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>Nov. 6, 1980   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Moreland Mem. Pk.                              |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Parkville, Balto., Md.   |  | 24. FUNERAL DIRECTOR<br>ROBERT C. ALTENBURG FUNERAL HOME, INC.<br>6009 Harford Rd., Balto., Md. 21214   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 6 1980  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]                                      |  |

(14)

1944

1945

1946

1947

1948

1949

1950

1951

1952

1953

1954

1955

1956

1957

1958

1959

1960

1961

1962

1963



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

2 8

1 8 1

REG. NO.

|   |   |   |  |  |  |
|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>HILDA LENA HOWARD</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11-10-80</b>                             |  | 2b. HOUR<br><b>12:40 AM</b>  |
| 3. SEX<br><b>FEMALE</b>   | 4. RACE<br><b>WHITE</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>NOVEMBER 27, 1911</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b> YRS.<br>IF UNDER 1 YEAR: MONTHS DAYS<br>IF UNDER 24 HRS: HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY, MD.</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE, MD.</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>CHURCH HOSPITAL, INC.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>HOUSE WORK.</b>  |
| 13a. STATE<br><b>MD.</b>  |   |   | 13b. COUNTY<br><b>-----</b>  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>? WELTY</b>  |   |   | 15. MOTHER'S MAIDEN NAME<br>MIDDLE LAST<br><b>MATTIE ?</b>                         |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>216-32-0674M</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>4103 ARDLEY AVE.<br/>BALTO., 21213, MD.</b>                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY FAILURE</b><br>1540 }<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>ADVANCED CANCER RECTOSIGMOID REGION</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                             | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 9 28 19 80</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>100 N. BROADWAY BALTIMORE, MD. 21203</b>                 |  |
| 22a. I certify that (I) this hospital attended the deceased from <b>11-10-80</b> to <b>10-10-80</b> , that (I) we last saw the deceased alive on <b>11-10-80</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)  |   |   |  |  |  |
| 22b. SIGNATURE<br><i>Isburnway</i>  |   | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>11-10-80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. G. BURUSWAMY, MD.</b>   |   | 22e. ADDRESS<br><b>CHURCH HOSPITAL CORPORATION<br/>100 N. BROADWAY BALTIMORE, MD. 21203</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |   | 23b. DATE<br><b>11-11-80.</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>OAK LAWN CEMETERY</b>   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>7225 EASTERN BLVD. BA. CO., MD.</b>  |   | 23e. NAME OF CEMETERY OR CREMATORY  |  | 23f. LOCATION  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Charles S. Jellison &amp; Son, Inc.</b>  |   | ADDRESS<br><b>6224 EASTERN AVE.<br/>BALTO., 21224, MD.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 12 1980</b>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><i>Robert M. Brady</i>  |   |   |  |  |  |

1997, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

• 100% • 100% • 100%

11-15-05

118. 0551E 02100

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

0907 BP  
DHMH-16 30M 2/80  
(VRA 15, 4)

2/6  
FOR  
1. STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

2 8 1 8 2

REG. NO.

|   |   |   |   |   |  |
|---|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>JOHN H. HOWARD</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 1 80</b> |   | 2b. HOUR<br><b>5:35a M</b>                   |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>BLACK</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 14 26</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>54</b><br>YRS. MONTHS DAYS HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE</b> MD.                |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>V A M C BALTIMORE, MARYLAND</b> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)            |  |
| 13a. STATE<br><b>MARYLAND</b>   |   | 13b. COUNTY   |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                       |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 13e. STREET ADDRESS<br><b>2516 ASGUTH STREET 21218</b>  |   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Daniel H. Howard</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Louise Prettyman</b>  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>WW11 578 28 3473</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Margaret A. Howard 2516 N. Aisquith</b>      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Metastatic squamous lung cancer</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |   |   |   |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)    |   |   |  |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                           |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>SEPTEMBER 11</b> , 19 <b>80</b> , to <b>NOVEMBER 1</b> , 19 <b>80</b> , that <input checked="" type="checkbox"/> (we) lost<br>saw the deceased alive on <b>NOVEMBER 1</b> , 19 <b>80</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated<br>above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death. |   |   |   |   |  |
| 22b. SIGNATURE<br><b>Howard Freehand MD</b>   |   | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>11/1/80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Howard Freehand MD</b>  |   | 22e. ADDRESS  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |   | 23b. DATE<br><b>11/7/80</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Memorial Pk.</b>           |  |
| 23d. LOCATION<br>CITY OR TOWN<br><b>Baltimore</b>   |   | COUNTY<br><b>Co. MD</b>   |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>   |   | 1101 E. North Ave.  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 3 1980</b>                          |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |   |   |   |   |  |

1980

1980

1980

1980

1980

1980

1980

1980

1980

1980

1980

1980

1980

1980

1980

1980

1980

1980

1980

1980

1980

1980

1980

1980

1980

1980

1980

1980

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 1 8 3

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>John A. Howe</b>   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 01, 1980</b>   |  | 2b. HOUR<br><b>7:15pm</b>   |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>CAUCASIAN</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>02 22 01</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. <b>BALTIMORE CITY OR COUNTY OF DEATH</b><br><b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>The Johns Hopkins Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>TREE TRIMMER</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>SELF EMPLOY</b>   |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>---</b>  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>-----</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ETMA</b>   |  | 13e. STREET ADDRESS<br><b>809 N. LUZERNE AVE.</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>215186360</b>   |  | 17. INFORMANT ADDRESS<br><b>SOPHIA HOWE 809 N. LUZERNE AVE.</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Melanotic squamous cell ca</b><br><b>1991</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |  |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>4 months</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>COPD, hypercalcemia</b>   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/30</b> 19 <b>80</b> , to <b>11/1</b> 19 <b>80</b> , that (I) (we) lost<br>saw the deceased alive on <b>11/1</b> 19 <b>80</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>[Signature]</b>  |  |  |  | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>11/1/80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JB Lefkowitz MD</b>   |  |  |  | 22e. ADDRESS<br><b>JHH Balt, Md 21205</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>11/5/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ST. STANISLAUS</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO BALTO MD</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>[Signature]</b> ADDRESS <b>1211 Chesaw Ave.</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 7 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |

00-82

COLLECTIONS



LIBRARY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8028184

FOR  
1- STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |   |
|--|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>ROY L HOWELL   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 21 80                  |   | 2b. HOUR<br>4 AM  |
| 3. SEX<br>Male   | 4. RACE<br>Black   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6 25 25   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>55 YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>N.C.  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>John L. Deaton Medical Center |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |   | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore  | 13c. CITY OR TOWN<br>Baltimore                                   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>3217 Vickers Road  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Frank Howell   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Annie Harris Howell  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>216-18-3837  |  | 17. INFORMANT ADDRESS<br>Roy Douglass Howell 3217 Vickers Road                                  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Aggressive Cell CA</u><br>1991<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Esophageal Abscess</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Histiocytic Lymphoma</u>   |  |   |  |   |   |
| 19a. DATE OF OPERATION<br><u>11-18</u>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>Lymphoma</u>   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11-18</u> , 19 <u>80</u> , to <u>11-21</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>11-21</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                  |  |   |  |   |   |
| 22b. SIGNATURE<br><u>William C. March</u>  |  | DEGREE<br>N ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>      |  | 22c. DATE SIGNED<br>11-27-80  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>WILLIAM C. MARCH  |  | 22e. ADDRESS<br>611 P. Charles Street   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>11/24/80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cheltenham VA Cemetery                                    |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Cheltenham MD  |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>WILLIAM C. MARCH FUNERAL HOME INC. 1101 E. North Ave  |  |   |   |
| 25a. DATE REC'D. BY REGISTRAR<br>NOV 25 1980   |  | 25b. REGISTRAR'S SIGNATURE<br><u>W. C. March</u>  |  |   |   |



U.S. C.B.



DOX COLON

5/1/50



U.S. C.B.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |  |  | 8 0 2 8 1 8 5   |        |  |                  |
|---|--|--|--|--|--|---|--|--|--|---|--------|--|------------------|
| 1. FOR STATE REGISTRAR  |  | REG. NO.   |  |  |  |   |  |  |  |   |        |  |                  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST Alpha  |  | MIDDLE I.  |  | LAST Hoyle  |  | 2a. DATE OF DEATH  |  | MONTH 11  | DAY 15 | YEAR 80                                      | 2b. HOUR 3:10 PM |
| 3. SEX Female   |  | 4. RACE White  |  | 5. DATE OF BIRTH   |  | MONTH 11  |  | DAY 01   |  | YEAR 1897   |        | 6. AGE (IN YEARS (LAST BIRTHDAY)) 83 YRS.    |                  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  | Baltimore City   |  | MD.   |        |  |                  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  | Baltimore  |  | Baltimore City Hospital   |        | Housewife                                    |                  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS                                      |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |        | 812 Loalan Avenue                            |                  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT  |  | ADDRESS   |        | 812 Loalan Avenue                            |                  |
| FIRST David   |  | MIDDLE C.  |  | LAST Beck  |  | FIRST Sophia  |  | MIDDLE R.  |  | LAST Connolly   |        | Balto., Md. 21222                            |                  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY.   |  | IMMEDIATE CAUSE (a)  |  | DUE TO, OR AS A CONSEQUENCE OF   |  | (b)   |  | DUE TO, OR AS A CONSEQUENCE OF                           |  | (c)   |        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                  |
| 4100  |  | cardio pulmonary arrest.   |  | myocardial infarction  |  | ASCVD   |  | ~ 10 min   |  | ~ 24 hrs.   |        | Consolidating                                |                  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.   |  |  |  |  |  |   |  |  |  |   |        |  |                  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?  |  | YES <input type="checkbox"/> NO <input type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |        |  |                  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |   |        |  |                  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION  |  | STREET  |  | CITY OR TOWN   |  | COUNTY  |        | STATE  |                  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/14, 1980, to 11/15, 1980, that (I) (we) last saw the deceased alive on 11/15, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |  |  |   |        |  |                  |
| 22b. SIGNATURE  |  | 22c. DEGREE  |  | 22d. DATE SIGNED   |  | 22e. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  |  |   |        |  |                  |
| 22f. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22g. ADDRESS   |  |  |  |   |  |  |  |   |        |  |                  |
| Patricia J. Coon  |  | Balto. CC Hosp.  |  |  |  |   |  |  |  |   |        |  |                  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  | CITY OR TOWN   |  | COUNTY  |        | STATE  |                  |
| Burial  |  | 11/18/1980   |  | Meadowridge Mem.   |  | Dorsey  |  | Howard   |  | Maryland  |        |  |                  |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |  |  |   |        |  |                  |
| Duda-Ruck, Inc.   |  | NOV 18 1980  |  | [Signature]  |  |   |  |  |  |   |        |  |                  |
| 7922 Wise Avenue  |  | Dundalk, Md. 21222   |  |  |  |   |  |  |  |   |        |  |                  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 8 0 2 8 1 8 6

1. FOR  
STATE  
REGISTRAR

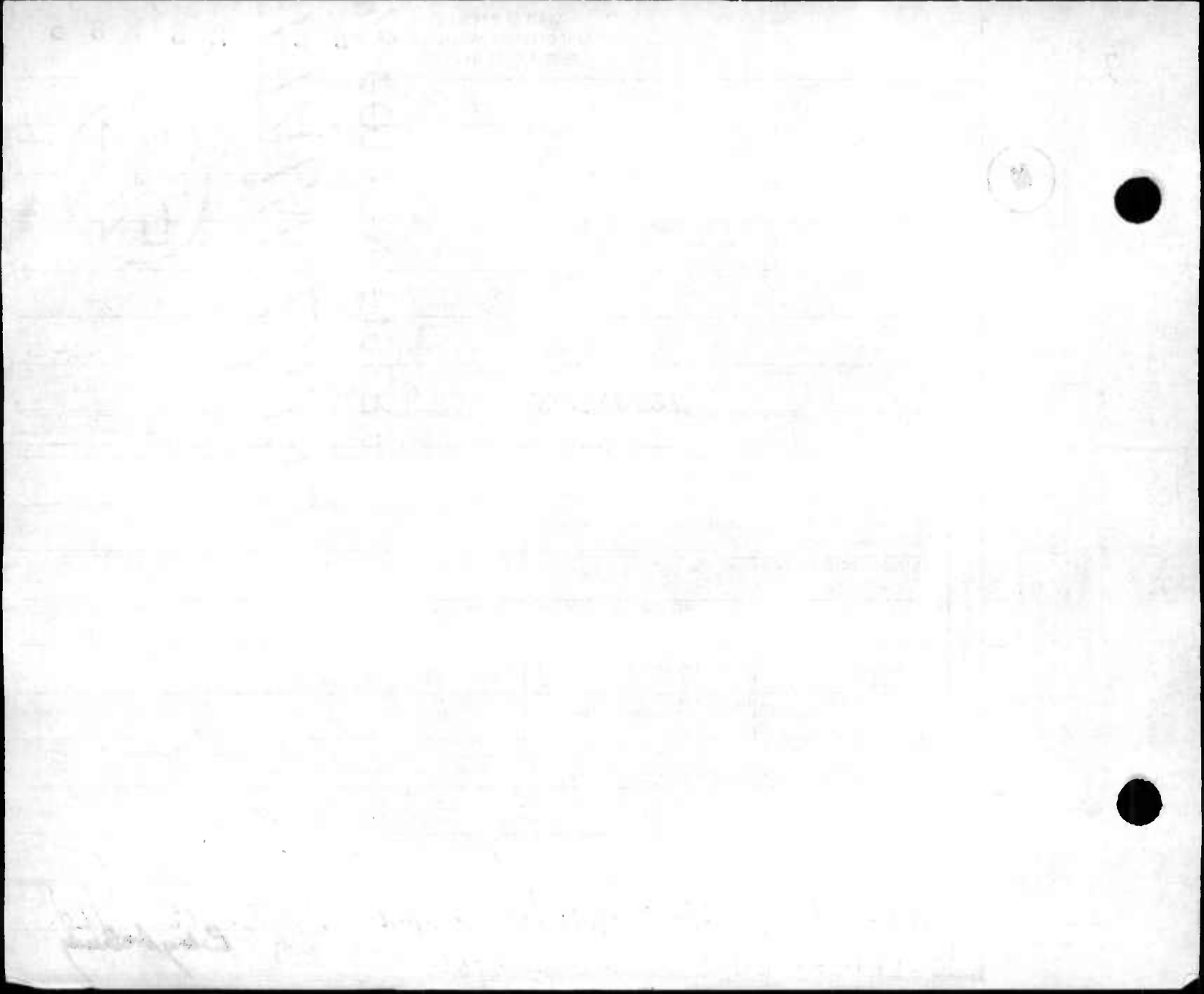
|   |   |   |   |   |   |
|---|---|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Lucy R. HUDGINS                                       |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 24 80                               |   | 2b. HOUR<br>1258 A.M.   |
| 3. SEX<br>Female  | 4. RACE<br>Black  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 13 17   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>63 YRS.                | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VA.  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                    |   |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>South Balt. Gen. Hosp. |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>housewife |   | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md. |   |   | 13b. COUNTY<br>Baltimore  | 13c. CITY OR TOWN<br>Baltimore                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Jesse WATTY   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MARY JENKINS                 |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>220 30 6175  |   | 17. INFORMANT<br>ADDRESS<br>(husband) Leon Hudgins (same) |   |

|  |  |   |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Gastrointestinal Bleeding</u><br>5715<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Cirrhosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
|--|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

|  |  |  |   |
|--|--|--|---|
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov. 8</u> , 19 <u>80</u> , to <u>Nov 24</u> , 19 <u>80</u> , that (I) (we) lost<br>saw the deceased alive on <u>Nov 24</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |   |
| 22b. SIGNATURE<br><u>Susan Voss, MD</u>  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED<br>11/24/80   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>SUSAN VOSS, MD  |  | 22e. ADDRESS<br>3001 S. HANOVER ST. Baltimore, Md. 21230                       |   |

|  |                       |   |  |
|--|-----------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial | 23b. DATE<br>11-29-80 | 23c. NAME OF CEMETERY OR CREMATORY<br>Arboretum Mem. Park | 23d. LOCATION<br>CITY, TOWN, COUNTY, STATE<br>Baltimore, Co. Md. |
| 24. FUNERAL DIRECTOR<br>NAME<br>Joseph L. Russ         |                       | 25. DATE REC'D. BY REGISTRAR<br>DEC 1 1980                |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 28187

REG. NO.

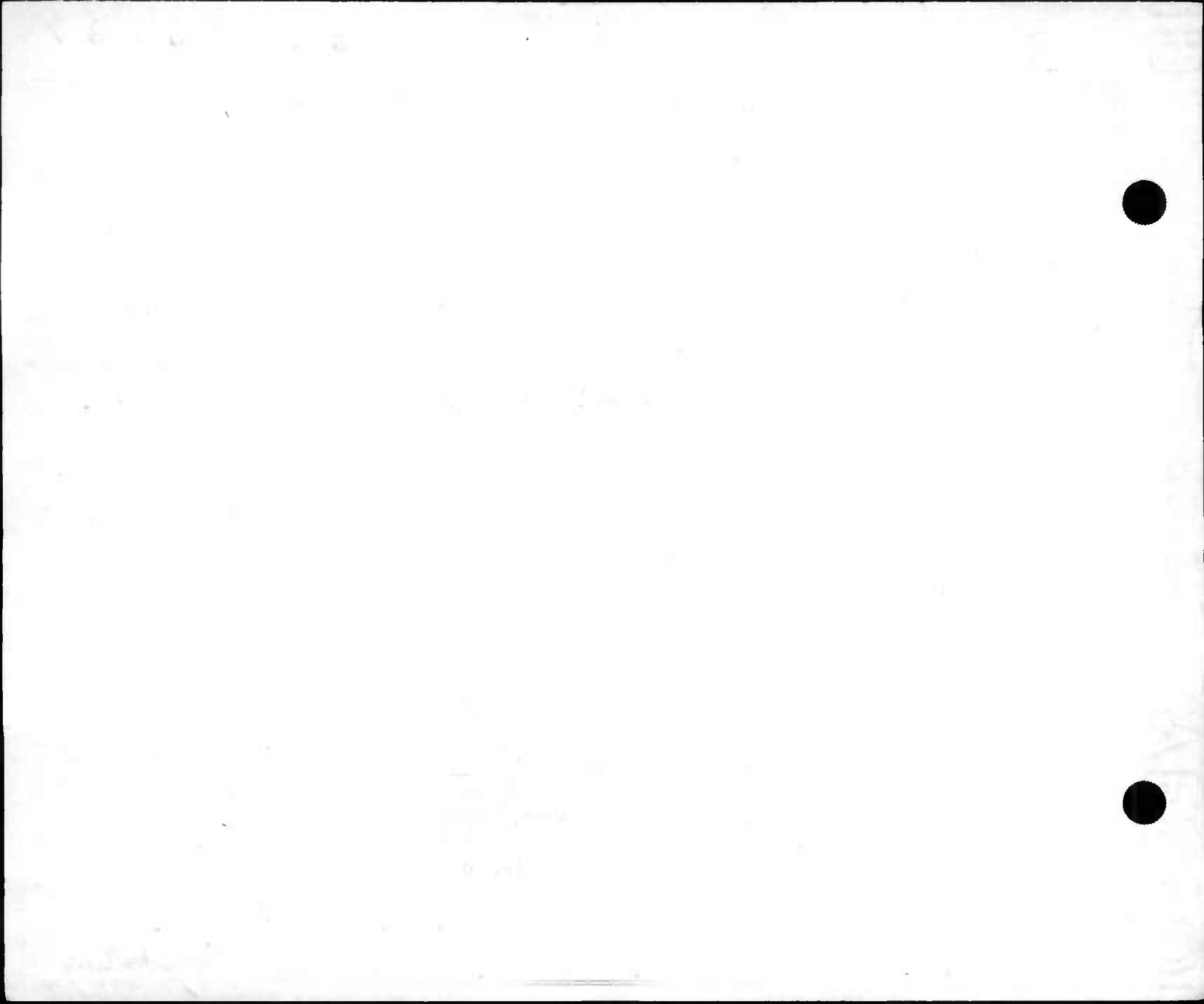
1- FOR  
STATE  
REGISTRAR

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>LUCY HUDSON (PERSON)</b>   |  | 2a DATE OF DEATH MONTH DAY YEAR<br><b>November 1, 1980</b>         |  | 2b HOUR<br><b>M</b>  |  |
| 3 SEX<br><b>Female</b>  |  | 4 RACE<br><b>Negro</b>   |  | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>8 27 19</b>   |  |
| 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>61</b> YRS   |  | # UNDER 1 YEAR<br>MONTHS DAYS                                      |  | # UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VA</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                          |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD   |  | 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>                       |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>702 McCabe Avenue</b>                       |  |
| 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |
| 13a STATE<br><b>MD</b>  |  | 13b COUNTY   |  | 13c CITY OR TOWN<br><b>Baltimore</b>   |  |
| 13d INSIDE CITY LIMITS?<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>  |  | 13e STREET ADDRESS<br><b>702 McCabe Avenue</b>                     |  |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><b>John Hudson</b>  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Emma Bland</b>     |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |  | 16b SOCIAL SECURITY NO<br><b>218-09-7510</b>                       |  | 17 INFORMANT ADDRESS<br><b>Emma Cufield 711 1/2 McCabe Ave.</b>  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART I DEATH WAS CAUSED BY:<br><b>1539</b> IMMEDIATE CAUSE (a) <b>MALNUTRITION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>PROBABLE COLONIC CA.</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:   |  |  |  |  |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  | 20a AUTOPSY?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE  |  |
| 22a I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>JULY 1</b> , 19 <b>80</b> , to <b>NOV 1</b> , 19 <b>80</b> , that (I) ( <del>was</del> ) lost<br>saw the deceased alive on <b>AUGUST</b> , 19 <b>80</b> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated<br>above, (I) ( <del>was</del> ) ( <del>did not</del> ) view the body after death. |  |  |  |  |  |
| 22b SIGNATURE<br><b>Robert J. Mandel</b> DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>  |  |  |  | 22c DATE SIGNED<br><b>11/3/80</b>  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ROBERT J. MANDEL</b>   |  |  |  | 22e ADDRESS<br><b>601 N. BROADWAY BALT. MD 21205</b>   |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b DATE<br><b>11/8/80</b>   |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Westview Mem. Pk.</b>  |  |
| 23d LOCATION CITY OR TOWN<br><b>Baltimore Co.</b>   |  | 23e COUNTY<br><b>MD</b>  |  | 23f STATE  |  |
| 24 FUNERAL DIRECTOR NAME<br><b>Wm. C. March F/H</b>   |  | 24b ADDRESS<br><b>1101 E. North Ave.</b>                           |  | 25a DATE REC'D. BY REGISTRAR<br><b>NOV 5 1980</b>  |  |
| 25b REGISTRAR'S SIGNATURE<br><b>Robert J. Mandel</b>  |  |  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.







03 35 11

•

55 1 10

1919

II. Will



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSMIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |  |         |  |   |  |                   |  |   |  |  |  |   |  |                |  |                                   |  |  |  |   |  |  |  |  |  |  |  |  |  |
|--|--|---------|--|---|--|-------------------|--|---|--|--|--|---|--|----------------|--|-----------------------------------|--|--|--|---|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |         |  |   |  |                   |  |   |  | 80128189   |  |   |  |                |  |                                   |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |         |  |   |  |                   |  |   |  | 2a. DATE KNOWN OF DEATH  |  |   |  |                |  |                                   |  |  |  | 2b. HOUR  |  |  |  |  |  |  |  |  |  |
| FIRST MIDDLE LAST<br>Carl Vernon Hunt  |  |         |  |   |  |                   |  |   |  | <input checked="" type="checkbox"/> MONTH DAY YEAR<br><input type="checkbox"/> 11 21 19 80 |  |   |  |                |  |                                   |  |  |  | M   |  |  |  |  |  |  |  |  |  |
| 3. SEX   |  | 4. RACE |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS) |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS.   |  | 7c. DATE PRONOUNCED DEAD                                      |  | MONTH DAY YEAR |  | 24 HOUR                           |  |  |  |   |  |  |  |  |  |  |  |  |  |
| Male   |  | Black   |  | 12-28-16  |  | 67 YRS            |  | MONTHS DAYS   |  | HOURS MIN  |  | 11 21 19 80   |  | 6:20           |  | P M                               |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |         |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |                   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |  |                |  |                                   |  |  |  |   |  |  |  |  |  |  |  |  |  |
| Balto., Md.  |  |         |  | U.S.  |  |                   |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                    |  |  |  | Baltimore City, MD.   |  |                |  |                                   |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                   |  |   |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  |                |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |  |   |  |  |  |  |  |  |  |  |  |
| Baltimore  |  |         |  | 2555 McCulloh Street  |  |                   |  |   |  |  |  | retired   |  |                |  |                                   |  |  |  |   |  |  |  |  |  |  |  |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |         |  |   |  |                   |  |   |  | 13d. INSIDE CITY LIMITS?   |  |   |  |                |  |                                   |  |  |  | 13e. STREET ADDRESS   |  |  |  |  |  |  |  |  |  |
| 13a. STATE   |  |         |  |   |  |                   |  |   |  | 13b. COUNTY  |  |   |  |                |  |                                   |  |  |  | 13c. CITY OR TOWN   |  |  |  |  |  |  |  |  |  |
| Md.  |  |         |  |   |  |                   |  |   |  |  |  |   |  |                |  |                                   |  |  |  | Balto.  |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME  |  |         |  |   |  |                   |  |   |  | 15. MOTHER'S MAIDEN NAME   |  |   |  |                |  |                                   |  |  |  |   |  |  |  |  |  |  |  |  |  |
| FIRST MIDDLE LAST  |  |         |  |   |  |                   |  |   |  | FIRST MIDDLE LAST  |  |   |  |                |  |                                   |  |  |  |   |  |  |  |  |  |  |  |  |  |
| Leon Hunt Sr.  |  |         |  |   |  |                   |  |   |  | Althea Hunt  |  |   |  |                |  |                                   |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |  |         |  |   |  |                   |  |   |  | 16b. SOCIAL SECURITY NO.   |  |   |  |                |  |                                   |  |  |  | 17. INFORMANT ADDRESS   |  |  |  |  |  |  |  |  |  |
| yes  |  |         |  |   |  |                   |  |   |  | 216-016-128  |  |   |  |                |  |                                   |  |  |  | Carl Hunt Jr. 2555 McCulloh St.   |  |  |  |  |  |  |  |  |  |
| 2/15/42  |  |         |  |   |  |                   |  |   |  |  |  |   |  |                |  |                                   |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |         |  |   |  |                   |  |   |  |  |  |   |  |                |  |                                   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |  |  |  |  |  |  |  |  |
| PART I DEATH WAS CAUSED BY:  |  |         |  |   |  |                   |  |   |  |  |  |   |  |                |  |                                   |  |  |  |   |  |  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease  |  |         |  |   |  |                   |  |   |  |  |  |   |  |                |  |                                   |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 4292 (b) DUE TO, OR AS A CONSEQUENCE OF  |  |         |  |   |  |                   |  |   |  |  |  |   |  |                |  |                                   |  |  |  |   |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |  |         |  |   |  |                   |  |   |  |  |  |   |  |                |  |                                   |  |  |  |   |  |  |  |  |  |  |  |  |  |
| (c) DUE TO, OR AS A CONSEQUENCE OF   |  |         |  |   |  |                   |  |   |  |  |  |   |  |                |  |                                   |  |  |  |   |  |  |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |  |         |  |   |  |                   |  |   |  |  |  |   |  |                |  |                                   |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |         |  |   |  |                   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |                |  |                                   |  |  |  | 20. AUTOPSY?  |  |  |  |  |  |  |  |  |  |
|  |  |         |  |   |  |                   |  |   |  |  |  |   |  |                |  |                                   |  |  |  | Head Only YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |         |  |   |  |                   |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  |   |  |                |  |                                   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |  |  |  |  |  |  |  |  |  |
|  |  |         |  |   |  |                   |  |   |  | P.M. 19  |  |   |  |                |  |                                   |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |  |         |  |   |  |                   |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                |  |   |  |                |  |                                   |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                |  |  |  |  |  |  |  |  |  |
|  |  |         |  |   |  |                   |  |   |  |  |  |   |  |                |  |                                   |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |         |  |   |  |                   |  |   |  |  |  |   |  |                |  |                                   |  |  |  |   |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE   |  |         |  |   |  |                   |  |   |  | TITLE (SPECIFY)  |  |   |  |                |  |                                   |  |  |  | DATE SIGNED   |  |  |  |  |  |  |  |  |  |
| Virginia L. Dolan  |  |         |  |   |  |                   |  |   |  | Assistant  |  |   |  |                |  |                                   |  |  |  | 11/22/80  |  |  |  |  |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |  |         |  |   |  |                   |  |   |  | ADDRESS  |  |   |  |                |  |                                   |  |  |  |   |  |  |  |  |  |  |  |  |  |
| Virginia L. Dolan, M.D.  |  |         |  |   |  |                   |  |   |  | 111 Penn Street  |  |   |  |                |  |                                   |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |         |  |   |  |                   |  |   |  | 23b. DATE  |  |   |  |                |  |                                   |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |  |  |  |  |  |  |  |  |
| Burial   |  |         |  |   |  |                   |  |   |  | 11/26/80   |  |   |  |                |  |                                   |  |  |  | Arbutus Mem. Pk.  |  |  |  |  |  |  |  |  |  |
| 23d. LOCATION CITY OR TOWN   |  |         |  |   |  |                   |  |   |  | COUNTY   |  |   |  |                |  |                                   |  |  |  | STATE   |  |  |  |  |  |  |  |  |  |
| Arbutus, Md.   |  |         |  |   |  |                   |  |   |  |  |  |   |  |                |  |                                   |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME  |  |         |  |   |  |                   |  |   |  | ADDRESS  |  |   |  |                |  |                                   |  |  |  | 25a. DATE REC'D. BY REGISTRAR   |  |  |  |  |  |  |  |  |  |
| Leroy O. Dyett   |  |         |  |   |  |                   |  |   |  | 4600 Liberty Heights Ave   |  |   |  |                |  |                                   |  |  |  | NOV 25 1980   |  |  |  |  |  |  |  |  |  |

25

NOV 2 1964

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 1 2 8 1 9 0  
CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |  |   |
|---|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>HURT RAYMOND</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOV 6 80</b>  |  | 2b. HOUR<br>M<br><b>M</b>   |
| 3 SEX<br><b>MALE</b>  | 4 RACE<br><b>BLACK</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 11 25</b>  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>55</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS.</b>  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Va.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. <b>BALTIMORE CITY OR COUNTY OF DEATH</b><br><b>balto. city</b> MD.                           |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO.</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>balto. city</b>          |  | 12b. KIND OF BUSINESS OR INDUSTRY   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |   |  |   |
| 13a. STATE<br><b>Md.</b>  | 13b. COUNTY  | 13c. CITY OR TOWN<br><b>Balto.</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>1529 N. Bond Street</b>                                    |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Jessie Hurt</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Levirt Wood</b>                             |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>224-26-5169</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Viola Hurt 1529 N. Bond Street</b>                    |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Apnea</b><br>2875<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Brainstem Bleeding</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Thrombocytopenia</b> |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 hrs.</b><br><b>12 hrs.</b><br><b>3 weeks</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |   |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)        |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>11/3/80 11/6 80</b>          |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/3/80</b> to <b>11/6 80</b> , that (I) (we) last saw the deceased alive on <b>11/6 80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.  |  |   |   |  |   |
| 22b. SIGNATURE<br><b>R. Carroll</b>   |  | DEGREE  |   | 22c. DATES SIGNED<br><b>11/6/80</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CARROLL</b>   |  | 22e. ADDRESS<br><b>Union Mem. Hosp.</b>   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>11/10/80</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>PLEASANT GROVE CEM</b>                      |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>KEYSVILLE VA.</b>  |  |   |   |  |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>WM C. MARCH FUNERAL HOME 1101 E. NORTH</b>   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 10 1980</b>                                  |   |
|   |  |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>L. J. [Signature]</b>                               |   |

27

RECEIVED

1914

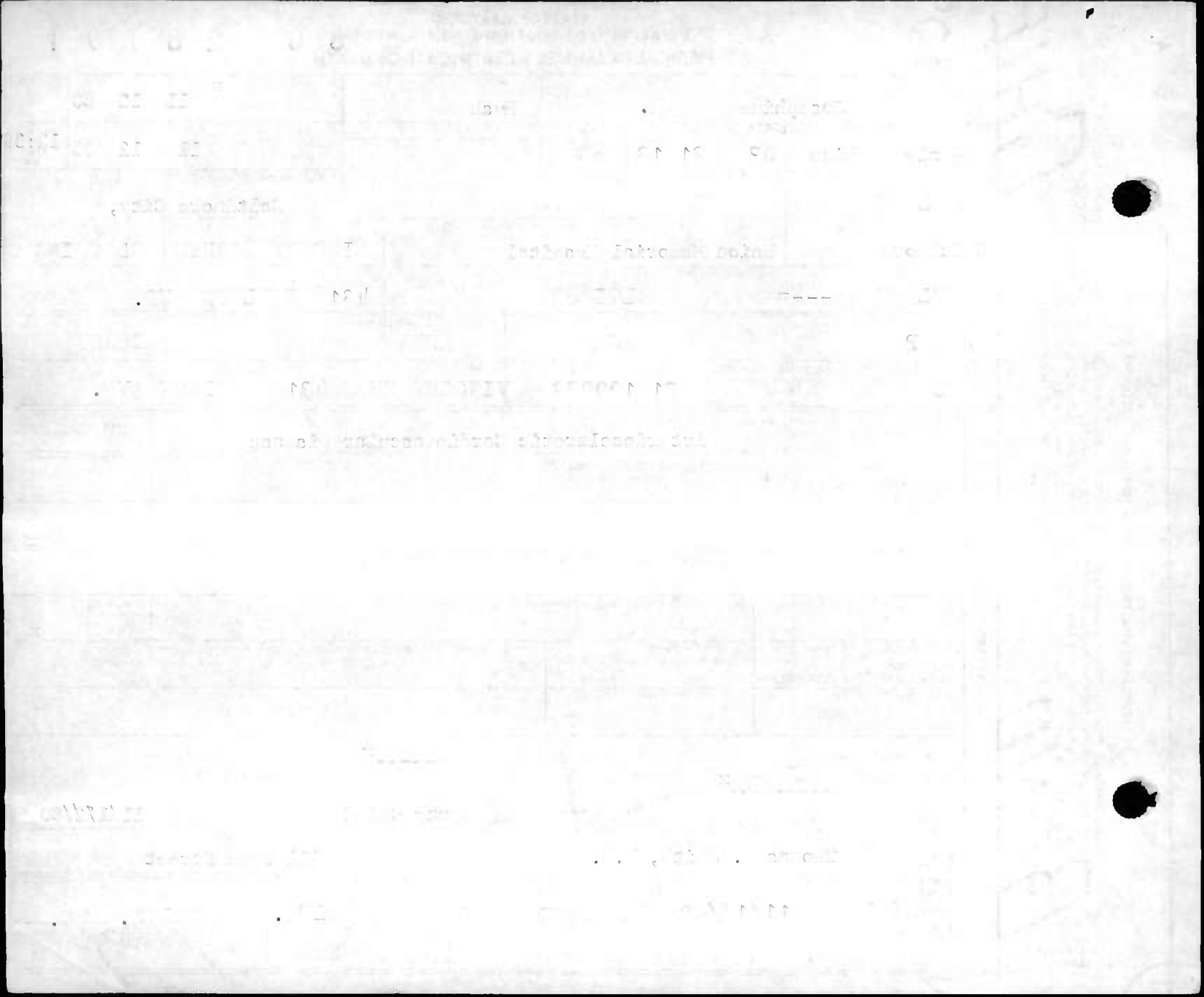
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

8 0 2 8 1 9 1

|   |   |   |   |   |  |
|---|---|---|---|---|--|
| 1. FOR STATE REGISTRAR  |   | 2a. DATE KNOWN OF DEATH   |   | 2b. HOUR  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |   | 2a. DATE KNOWN OF DEATH   |   | 2b. HOUR  |  |
| Josephine M. Hush   |   | MONTH DAY YEAR<br>11 12 80  |   | M<br>12:39 AM   |  |
| 3. SEX  | 4. RACE   | 5. DATE OF BIRTH  | 6. AGE (IN YEARS)   | IF UNDER 1 YR.  | IF UNDER 24 HRS.                             |
| Female  | White   | MONTH DAY YEAR<br>02 21 13  | LAST BIRTHDAY<br>67 YRS.  | MONTHS DAYS   | HOURS MIN                                    |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |   |  |
| MARYLAND  | USA   | <input checked="" type="checkbox"/> NEVER MARRIED<br><input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED | Baltimore City, MD.   |   |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   | 12b. KIND OF BUSINESS OR INDUSTRY                                   |   |  |
| Baltimore   | Union Memorial Hospital   | BINDERY WORKER  | CLOTHING  |   |  |
| 13a. STATE  |   | 13b. COUNTY   | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS                          |
| MARYLAND  | ----  | BALTIMORE   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 4318 SHELDON AVE.   |  |
| 14. FATHER'S NAME   |   | 15. MOTHER'S MAIDEN NAME  |   |   |  |
| FIRST MIDDLE LAST<br>JOSEPH HAJEK   |   | FIRST MIDDLE LAST<br>ANNA CERNY   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |   | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT ADDRESS   |  |
| NO  |   | 215100039   |   | VINCENT HUSH 4318 SHELDON AVE.  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b><br>4292 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |   |   |   |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   | 20. AUTOPSY?  |  |
|   |   |   |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  |   |   |   |   |  |
| ACTUAL SIGNATURE  |   | TITLE (SPECIFY)   |   | DATE SIGNED   |  |
|   |   | Deputy Chief  |   | 11/12/80  |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |   | ADDRESS   |   |   |  |
| Thomas D. Smith, M.D.   |   | 111 Penn Street   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   | 23b. DATE   | 23c. NAME OF CEMETERY OR CREMATORY  | 23d. LOCATION CITY OR TOWN  | COUNTY  | STATE  |
| BURIAL  | 11/15/80  | PARKWOOD CEMETERY   | BALTO.  | BALTO.  | MD.  |
| 24. FUNERAL DIRECTOR NAME   |   | ADDRESS   |   | 25a. DATE REC'D. BY REGISTRAR   |  |
| John Ward   |   | 1211 Chesaco Ave.   |   | NOV 19 1980   |  |
|   |   |   |   | 25b. REGISTRAR'S SIGNATURE  |  |
|   |   |   |   |   |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 28192

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>(Adolph) ALVIN (Hutchings) HUTCHEN</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 29 80</b> |   |  | 2b. HOUR<br><b>4:55 PM</b>   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 23 36</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>43</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore City</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Provident</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Balto.</b>  |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Percy Hutchen</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Patsy King</b>  |  | 13e. STREET ADDRESS<br><b>1801 Bentalou St.</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>218-56-2294</b>  |  | 17. INFORMANT ADDRESS<br><b>Earlson Hutchins 320 N. Denison St.</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br><b>5712</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Carcinoma of end stage liver disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Pericardial effusion</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 years</b><br><b>1 month</b> |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Alcoholism</b>   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/15</b> , 19 <b>80</b> , to <b>11/29</b> , 19 <b>80</b> that (I) (we) last saw the deceased alive on <b>11/29</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Bayaniah Shalaby M.D.</b>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>11/29/80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |  | 22e. ADDRESS  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>12/4/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Church Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Danville, Va.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm C March F/H</b>  |  |   |  | ADDRESS<br><b>1101 E. North Ave.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 2 1980</b>   |  |
|  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Petry H. Hardy</b>   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

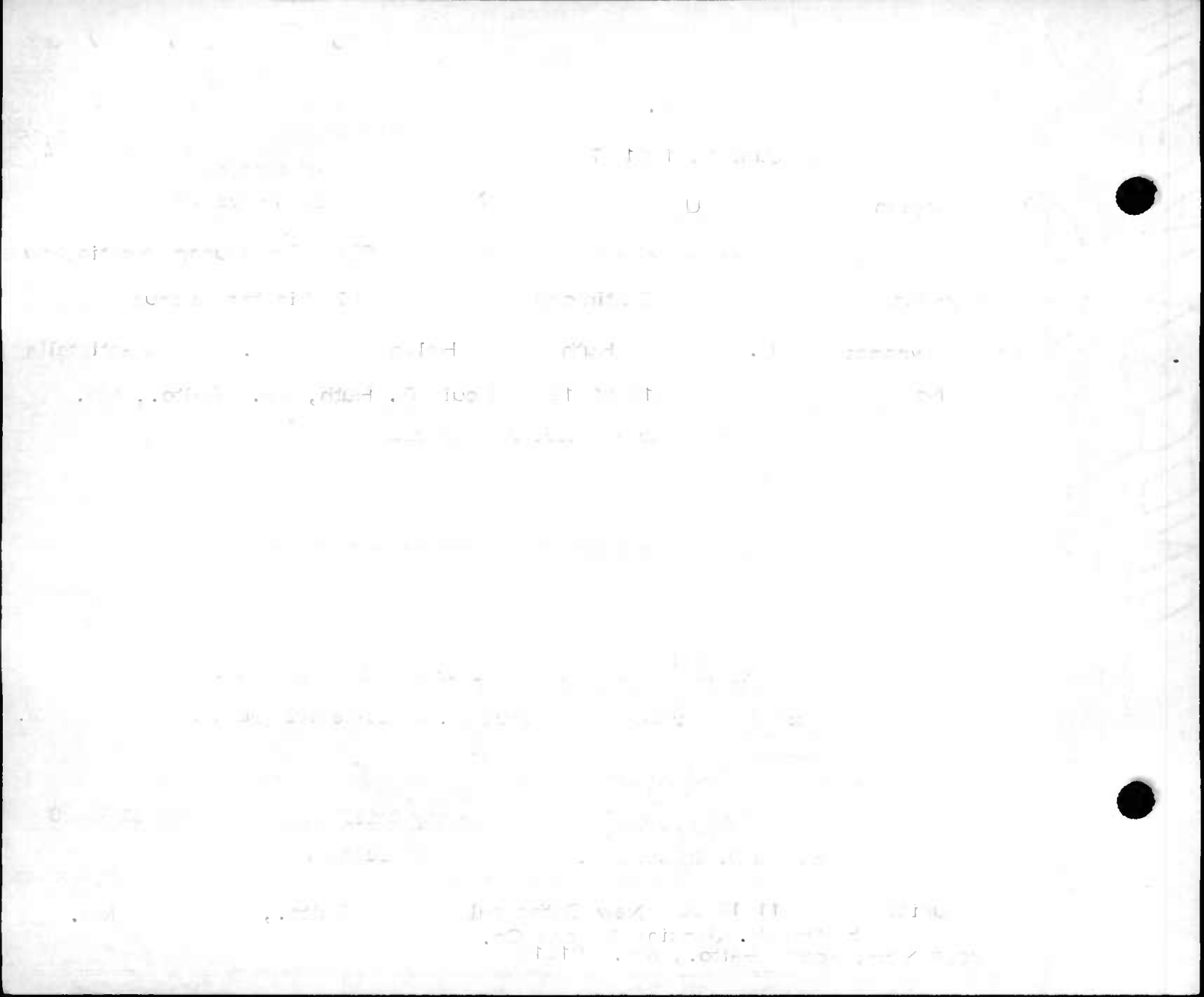




TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                  |   |   |                               |  |   |  |   |   | REG. NO. 28193   |  |   |   |  |  |
|--|------------------|---|---|-------------------------------|--|---|--|---|---|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>John M. Huth  |                  |   |   |                               |  |   |  |   |   | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br>11 10 1980  |  | 2b. HOUR<br>M<br>1:25                   |   |  |  |
| 3. SEX<br>male   | 4. RACE<br>white | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>June 3, 1901  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>79 YRS.                       | IF UNDER 1 YR.<br>MONTHS DAYS | IF UNDER 24 HRS.<br>HOURS MIN.   | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>11 10 1980  |  | 7d. HOUR<br>M<br>1:25                                     |   | 8. MARRIED<br>WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD. |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Union Memorial Hospital |   |                               | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Clerk-Treasurer |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Westinghouse         |   |  |  |   |   |  |  |
| 13a. STATE<br>Maryland   |                  |   |   |                               |  |   |  |   |   | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Baltimore          | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>327 Winston Avenue                  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Lawrence L. Huth   |                  |   |   |                               | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Helen A. Paptistella            |   |  |   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>212 03 1233 |   | 17. INFORMANT<br>ADDRESS<br>Louis G. Huth, Sr. Balto., Md. |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cranio-cerebral injuries</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |                  |   |   |                               |  |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):  |                  |   |   |                               |  |   |  |   |   |  |  |   |   |  |  |
| 19a. DATE OF OPERATION   |                  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                     |                               |  |   |  |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |   |   |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                  |   | 21b. TIME OF INJURY<br>HOUR MIN. MONTH DAY YEAR<br>12:40 M. 11-8-1980 |                               |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)<br>Pedestrian struck by auto. |  |   |   |  |  |   |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK  |                  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>road   |                               |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>York Rd. & McCabe Ave., Balto. Md.                     |  |   |   |  |  |   |   |  |  |
| 22a. I certify that I took charge of the remains described above, held in death resulted from <input type="checkbox"/> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |                  |   |   |                               |  |   |  |   |   |  |  |   |   |  |  |
| ACTUAL SIGNATURE<br><i>Thomas D. Smith</i>   |                  |   | TITLE (SPECIFY)<br>M.D. Deputy Chief                                  |                               |  | MEDICAL EXAMINER  |  |   | DATE SIGNED<br>11-10-80   |  |  |   |   |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Thomas D. Smith, M.D.  |                  |   | ADDRESS<br>111 Penn St.   |                               |  |   |  |   |   |  |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |                  |   | 23b. DATE<br>11/12/80   |                               | 23c. NAME OF CEMETERY OR CREMATORY<br>New Cathedral                              |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto., Md. |   |  |  |   |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Henry W. Jenkins & Sons Co.<br>ADDRESS<br>4905 York Road Balto., Md. 21212   |                  |   |   |                               |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 12 1980  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Barry McCreedy</i>       |   |  |  |   |   |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 1 9 4

REG. NO.

|  |   |  |  |   |
|--|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Blanche M. Hutson</b>   |   | 2a. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>05</b> YEAR <b>80</b>  |  | 2b. HOUR<br><b>1:45</b> M   |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH <b>4</b> DAY <b>19</b> YEAR <b>04</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b> YRS.   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MD.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO.</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Bon Secours Hosp.</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. STATE<br><b>Maryland</b>  |   | 13b. COUNTY  | 13c. CITY OR TOWN<br><b>Baltimore</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST <b>Frank</b> MIDDLE <b>L.</b> LAST <b>Kilmer</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Lillian</b> MIDDLE <b>I.</b> LAST   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>214-74-5408</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Mr. Francis M. Hutson, 1114 Daniels Ave.</b>                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4102</b> IMMEDIATE CAUSE (a) <b>acute massive anterior wall myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>hypertension arteriosclerotic</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>arterial hypertension</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 weeks</b><br><b>years</b>                  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I  |   |  |  |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |  |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/21</b> 19 <b>80</b> , to <b>11-05</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>11-05</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |   |  |  |   |
| 22b. SIGNATURE<br><b>Dr. [Signature]</b>   |   | DEGREE<br><b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11-05/80</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. [Signature]</b>  |   | 22e. ADDRESS<br><b>1540 W. Baltimore St Balt MD 21223</b>  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |   | 23b. DATE<br><b>11/8/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>                               |
| 23d. LOCATION<br>CITY OR TOWN<br><b>Baltimore,</b>   |   | COUNTY<br><b>Maryland</b>  |  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Witzke Funeral Home of Catonsville, P.A. 21228</b>  |   | 25. DATE REC'D. BY REGISTRAR<br><b>NOV 10 1980</b>   |  | 25b. [Signature]  |

1871

1872

1873

1874

1875

1876

1877

1878

1879

1880

TO HOSPITAL AND ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 80 28195  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |  |  |
| 1. DECEASED NAME FIRST MIDDLE LAST<br>FAY L. J. HYNSON  |  |  |  | 11-23-80 5:10 PM   |  |  |  |
| 3 SEX<br>Female   |  | 4 RACE<br>White  |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>May 18, 1921   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>59 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.  |  |
| 10 CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL                 |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home  |  |
| 13a. STATE<br>Maryland  |  |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore   |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>Everett Elihu Jackson   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Elizabeth Fay Leonard  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.   |  | 17 INFORMANT ADDRESS<br>Richard Hynson   |  | Same   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) METASTATIC BREAST CANCER<br>1749<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>4 mo.  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/23/80 19 to 11/23 19 80, that (I) (we) last saw the deceased alive on 11/23 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.                              |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>Yael Yokel MD   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>11/23/80   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Yael Yokel   |  | 22e. ADDRESS<br>UNION MEMORIAL HOSPITAL  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>11/25/80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parsons Cemetery   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Salisbury, Md.   |  |
| 24 FUNERAL DIRECTOR NAME<br>Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., Md. 21212   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 24 1980   |  | 25b. REGISTRAR'S SIGNATURE<br>L. J. Hynson   |  |



Family  
White  
May 19, 1961  
Baltimore City  
USA  
Baltimore  
Maryland  
Elliott  
Elliott Jackson  
Elizabeth  
Pay  
Leonard  
Sams  
Richard Hyman

Union Memorial Hospital

Burial  
Henry W. Jackson & Sons Co.  
1155 N. York Road, Baltimore, Md. 21215  
Parsons Cemetery  
Baltimore, Md.  
1155 N. York Road, Baltimore, Md. 21215

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 2 8 1 9 6  
CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |                              |   |  |
|---|--|---|--|---|------------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>EDWARD D. IDZI, Sr.</b>                                    |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11/16/80</b> |   | 2b. HOUR<br><b>3:50 P.M.</b> |   |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>01/27/11</b>   |                              | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69 Yrs.</b>             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Louisiana</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST AGNES HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RET/SELF E.</b>  |                              | 12b. Res. Equip. Products<br><b>Custom</b>                    |  |
| 13a. USUAL RESIDENCE (IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE COUNTY<br><b>Maryland Balto.</b> |  | 13c. CITY OR TOWN<br><b>Maryland</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                              | 13e. STREET ADDRESS<br><b>406 Fox Chapel Dr.</b>              |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>FRANK IDZI</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary IZDEBSKI</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |                              | 16b. SOCIAL SECURITY NO.<br><b>216-05-6046</b>                |  |
| 17. INFORMANT<br><b>Stanley D. Idzi,</b>  |  | ADDRESS<br><b>same as # 13e</b>   |  | 18. CAUSE OF DEATH  |                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                  |  |

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **CARDIO-RESPIRATORY FAILURE**  
DUE TO, OR AS A CONSEQUENCE OF  
(b) **METASTATIC CA LUNGL**  
DUE TO, OR AS A CONSEQUENCE OF  
(c) **CARCINOMA LUNGL**

1-2 hrs  
9 mos.  
9 mos.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

**Dehydration**

MEDICAL CERTIFICATION

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11-16-</b> 19 <b>80</b> , to <b>11-16-</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>11/16</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Stephen K. Paduissis</b>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11-16-80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>STEPHEN K. PADUSSI</b>  |  |  |  | 22e. ADDRESS<br><b>900 CATON AVE BALTIMORE MD 21229</b>  |  |  |  |

|   |  |                              |  |   |  |   |  |
|---|--|------------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>            |  | 23b. DATE<br><b>11-19-80</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sacred Heart of Mary</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Dundalk Maryland</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Ruck Towson Funeral Home, Inc.</b> |  |                              |  | ADDRESS<br><b>1050 York Rd. Towson, Md. 21204</b>                 |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 19 1980</b>                   |  |
|   |  |                              |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert M. Brady</b>              |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| Items 21a.-21f. & 22a.  |  |   |  | STATE OF MARYLAND  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  | 8 0 2 8 1 9 7   |  |  |  |   |  |                  |  |
|---|--|---|--|--|--|--|--|---|--|--|--|---|--|------------------|--|
| 1. FOR STATE REGISTRAR  |  |   |  | CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |   |  |                  |  |
| 1 DECEASED NAME (TYPE OR PRINT)   |  |   |  | 2a. DATE OF DEATH  |  | MONTH  |  | DAY   |  | YEAR   |  | 2b. HOUR  |  |                  |  |
| William Chesney Ingham  |  |   |  | 10   |  | 5  |  | 80  |  |  |  | 2 A M   |  |                  |  |
| 3 SEX   |  | 4 RACE  |  | 5 DATE OF BIRTH  |  | 6 AGE (IN YEARS LAST BIRTHDAY)   |  | 7 UNDER 1 YEAR  |  | 7 UNDER 24 HRS   |  |   |  |                  |  |
| Male  |  | White   |  | March 13, 1898   |  | 82   |  | MONTHS  |  | DAYS   |  | HOURS MIN   |  |                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?                            |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH  |  |   |  |  |  |   |  |                  |  |
| Balto. Md.  |  | U S A   |  |  |  | BALTIMORE CITY   |  |   |  |  |  | MD.   |  |                  |  |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |  |  |   |  |                  |  |
| BALTIMORE   |  | ST AGNES HOSPITAL                                       |  | Engineer Western   |  | Md. Railroad   |  |   |  |  |  |   |  |                  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  | 13b. INSIDE CITY LIMITS?   |  | 13c. STREET ADDRESS  |  |   |  |  |  |   |  |                  |  |
| 13a. STATE  |  |   |  | 13b. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 832 Stamford Rd.   |  |   |  |  |  |   |  |                  |  |
| Md.   |  |   |  |  |  |  |  |   |  |  |  |   |  |                  |  |
| 14 FATHER'S NAME  |  |   |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |   |  |  |  |   |  |                  |  |
| 14 FIRST MIDDLE LAST  |  |   |  | 15 FIRST MIDDLE LAST   |  |  |  |   |  |  |  |   |  |                  |  |
| William Thomas Ingham   |  |   |  | Sophia Henneberger   |  |  |  |   |  |  |  |   |  |                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |   |  | 16b. SOCIAL SECURITY NO.   |  | 17 INFORMANT   |  | ADDRESS   |  |  |  |   |  |                  |  |
| no  |  |   |  | 705 10 5578  |  | Mrs. Nellie B. Ingham  |  | 832 Stamford Rd. Balto. Md. 21229                                   |  |  |  |   |  |                  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |   |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |  |   |  |                  |  |
| PART I. DEATH WAS CAUSED BY:  |  |   |  |  |  |  |  |   |  |  |  |   |  |                  |  |
| IMMEDIATE CAUSE (a) CEREBRAL CONTUSION  |  |   |  |  |  |  |  |   |  |  |  |   |  |                  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |  |  |  |  |   |  |  |  |   |  |                  |  |
| (b) CEREBRAL CONTUSION  |  |   |  |  |  |  |  |   |  |  |  |   |  |                  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |  |  |  |  |   |  |  |  |   |  |                  |  |
| (c) CEREBRAL CONTUSION  |  |   |  |  |  |  |  |   |  |  |  |   |  |                  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |   |  |  |  |  |  |   |  |  |  |   |  |                  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |   |  |                  |  |
|   |  |   |  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |   |  |                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |  |  |   |  |                  |  |
|   |  |   |  | 6 10 P M. 9 10 19 80   |  | Fall while getting out of bed.   |  |   |  |  |  |   |  |                  |  |
| 21d. INJURY OCCURRED  |  |   |  | 21e. PLACE OF INJURY   |  | 21f. LOCATION  |  | CITY OR TOWN  |  | COUNTY   |  | STATE   |  |                  |  |
| WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK  |  |   |  | Home   |  | 832 Stamford Rd.   |  | Balto.,   |  | 21229  |  | Md.   |  |                  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 09-10-80, 19, to 10-5-80, 19, 80, that (I) (we) lost saw the deceased alive on 10-5-80, 19, 80, and that in my (our) opinion death occurred on the date, and hour and from the causes stated above, <del>that</del> (we) (did) (do not) view the body after death. |  |   |  |  |  |  |  |   |  | 22b. SIGNATURE   |  | DEGREE  |  | 22c. DATE SIGNED |  |
|   |  |   |  |  |  |  |  |   |  | ANanavati  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 10-5-80          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |  |  |  |  |  |   |  | 22e. ADDRESS   |  |   |  |                  |  |
| Nanavati  |  |   |  |  |  |  |  |   |  |  |  |   |  |                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  | CITY OR TOWN   |  | COUNTY  |  | STATE            |  |
| Burial  |  |   |  | 10-7 1980  |  | Loudon Park Cem.   |  | Balto.  |  |  |  |   |  | Md.              |  |
| 24 FUNERAL DIRECTOR   |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |   |  |                  |  |
| G. NAME Truman Schwab 5151 Balto. National Pike Balto. Md. 21229  |  |   |  |  |  | OCT 10 1980  |  |   |  |  |  |   |  |                  |  |

BP

DHMH-16 25M  
(VRA 15, 4) 1/79

1 2 3 4 5 6

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |  |  | REG. NO.  |  |
|---|--|---|--|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>DOROTHEA W. INMAN</b>  |  |   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>NOVEMBER 15, 1980</b>   |  | 2b. HOUR<br><b>12:19 AM</b>                             |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>MARCH 15, 1915</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>65</b>  |  | IF UNDER 1 YEAR MONTHS DAYS<br><b></b>   |  | IF UNDER 24 HRS. HOURS MIN.<br><b></b>                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. <b>BALTIMORE CITY OR COUNTY OF DEATH</b><br><b>BALTIMORE CITY MD.</b>                     |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOMEMAKER</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b></b>   |  |   |  |
| 13a. STATE<br><b>MD.</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>TOWSON</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>7111 YORK RD. 21212</b>  |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>SAMUEL H. WELLSCHLAGER</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>IRENE KRUMM</b>  |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>219-36-6524</b>  |  | 17. INFORMANT ADDRESS<br><b>MRS. KATHY MAXWELL 434 REGINA DR.</b>   |  |  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br><b>4241</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>LOW OUTPUT FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ACUTE STENOSIS</b> |  |   |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b></b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Mitral regurgitation, minimal coronary artery disease</b>   |  |   |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION<br><b>11/15/80</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>AORTIC STENOSIS, CARDIOGENIC SHOCK</b>   |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                    |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b></b>   |  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b></b>  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br><b></b>   |  |  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/15/80</b> to <b>11/15/80</b> , that (I) (we) last saw the deceased alive on <b>11/15/80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated.   |  |   |  |   |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>R C WURDTH</b>   |  |   |  | DEGREE<br><b>MD</b>   |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11/15/80</b>                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>R C WURDTH</b>  |  |   |  | 22e. ADDRESS<br><b>1535 McEneaney Street</b>  |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>NOV. 18, 80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>DRUID RIDGE CEM.</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MD.</b>                              |  |  |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>MITCHELL-WIEDEFELD HOME</b>   |  |   |  | ADDRESS<br><b>6500 YORK RD. 21212</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 20 1980</b>  |  |   |  |
|   |  |   |  |   |  |  |  | REGISTRAR'S SIGNATURE<br><b></b>   |  |   |  |



*Handwritten signature*

RECEIVED - JUNE 10 1964  
U.S. AIR FORCE - WASHINGTON, D.C.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 28199

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|   |  |   |  |   |   |  |   |  |  |  |  |
|---|--|---|--|---|---|--|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>DOROTHY V. INSCO</b>   |  |   | 2a. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>28</b> YEAR <b>80</b>  |   |   | 2b. HOUR<br><b>1:50 PM</b>   |   |  |  |  |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>WHITE</b>                       |  | 5. DATE OF BIRTH<br>MONTH <b>2</b> DAY <b>07</b> YEAR <b>12</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>   |  | IF UNDER 24 HRS.<br>HOURS <b></b> MIN. <b></b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BALTIMORE MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>  |   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>South Balt. Gen. Hosp.</b> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>   |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>N.A.</b> |  |  |
| 13a. STATE<br><b>MD.</b>  |  |   | 13b. COUNTY<br><b>Balt.</b>  |   | 13c. CITY OR TOWN<br><b>BALT.</b>                                 |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>2209 GAYLAWN DR.</b>   |  |  |
| 14. FATHER'S NAME<br>FIRST <b>ELIHU</b> MIDDLE <b>-</b> LAST <b>Rowley</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>BERTHA</b> MIDDLE <b>MA</b> LAST <b>HAMLIN</b>  |   |   |  |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  |   | 16b. SOCIAL SECURITY NO.<br><b>21503-1452</b>  |   |   | 17. INFORMANT<br><b>2209 GAYLAWN DR.</b>   |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiovascular Arrest</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>myocardial Infarction</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b> |  |   |  |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH     |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |   |  |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9/29</b> , 19 <b>80</b> , to <b>11/28</b> , 19 <b>80</b> , that (I) (we) lost<br>saw the deceased alive on <b>11/29</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                            |  |   |  |   |   |  |   |  |  |  |  |
| 22b. SIGNATURE<br><b>Sandra L. Howard MD.</b>   |  |   | DEGREE<br><b>MD.</b>   |   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |  | 22c. DATE SIGNED<br><b>11/28/80</b>              |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Sandra L. Howard MD.</b>  |  |   | 22e. ADDRESS<br><b>3001 S. Hanover St BAL. MD.</b>   |   |   |  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>  |  |   | 23b. DATE<br><b>Dec. 1, 1980</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem. Park</b> |  |   | 23d. LOCATION<br>CITY OR TOWN <b>Glen Burnie, A.A. Co.</b> COUNTY <b>Maryland</b> STATE <b></b>                            |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>McCutty Funeral Home, 130 E. Fort Ave. Balto. Md.</b> ADDRESS <b></b>   |  |   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 1 1980</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>P. J. H. H. H.</b>  |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1. The first part of the document is a list of names and addresses. The names are: John Doe, Jane Smith, and Bob Johnson. The addresses are: 123 Main St, New York, NY 10001; 456 Elm St, New York, NY 10002; and 789 Oak St, New York, NY 10003.

2. The second part of the document is a list of names and addresses. The names are: Alice Brown, Charlie White, and David Green. The addresses are: 101 Main St, New York, NY 10004; 202 Elm St, New York, NY 10005; and 303 Oak St, New York, NY 10006.

3. The third part of the document is a list of names and addresses. The names are: Emily Black, Frank Gray, and Grace Blue. The addresses are: 404 Main St, New York, NY 10007; 505 Elm St, New York, NY 10008; and 606 Oak St, New York, NY 10009.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3A should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |                              |  |  |  |                                    |  |  |  | 8 0 2 8 2 0 0  |  |   |  |                                |  |                               |  |
|--|--|------------------------------|--|--|--|------------------------------------|--|--|--|--|--|---|--|--------------------------------|--|-------------------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |                              |  | CERTIFICATE OF DEATH   |  |                                    |  | REG. NO.   |  |  |  |   |  |                                |  |                               |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |                              |  | FIRST MIDDLE LAST  |  |                                    |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR  |  |  |  | 2b. HOUR<br>M   |  |                                |  |                               |  |
| MARY   |  |                              |  | JABLECKI   |  |                                    |  | 11-10-80   |  |  |  | 12:40AM   |  |                                |  |                               |  |
| 3. SEX   |  | 4. RACE                      |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR   |  |                                    |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  |                                |  |                               |  |
| FEMALE   |  | WHITE                        |  | 1 / 6 / 1891   |  |                                    |  | 89   |  |  |  |   |  |                                |  |                               |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>      |  |                                    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MD.  |  |  |  |   |  |                                |  |                               |  |
| POLAND   |  | U.S.A.                       |  |  |  |                                    |  | BALTIMORE CITY   |  |  |  |   |  |                                |  |                               |  |
| 10. CITY OR TOWN OF DEATH  |  |                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  |  |                                    |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                                |  |                               |  |
| BALTIMORE  |  |                              |  | CHURCH HOSPITAL INC.   |  |                                    |  | HOUSEWIFE  |  |  |  | ATHOME  |  |                                |  |                               |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                              |  |  |  |                                    |  |  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS            |  |                               |  |
| 13a. STATE<br>MARYLAND   |  |                              |  |  |  |                                    |  |  |  |  |  | 13b. COUNTY<br>-----  |  | 13c. CITY OR TOWN<br>BALTIMORE |  | 1727 E. LOMBARD STREET 21 231 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |  |                              |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST  |  |                                    |  |  |  |  |  |   |  |                                |  |                               |  |
| ADAM KURAK   |  |                              |  | KATHERINE ?  |  |                                    |  |  |  |  |  |   |  |                                |  |                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |                              |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)  |  |                                    |  | 17. INFORMANT ADDRESS  |  |  |  |   |  |                                |  |                               |  |
| NO   |  |                              |  | 219 05 8565  |  |                                    |  | JENNIE QUINTELLA 1727 E. LOMBARD ST. 21231   |  |  |  |   |  |                                |  |                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u><br><u>4360</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>CEREBROVASCULAR ACCIDENT</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF |  |                              |  |  |  |                                    |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |                                |  |                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>ATRIAL FIBRILLATION</u>  |  |                              |  |  |  |                                    |  |  |  |  |  |   |  |                                |  |                               |  |
| 19a. DATE OF OPERATION   |  |                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |                                    |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |                                |  |                               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                              |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |  |  |   |  |                                |  |                               |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                              |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |                                    |  | 21f. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |  |  |   |  |                                |  |                               |  |
| 22a. I certify that this hospital attended the deceased from <u>80/6/10/72</u> 19 <u>80</u> to <u>11/10/19</u> 19 <u>80</u> , that <input checked="" type="checkbox"/> I saw the deceased alive on <u>11/10/19</u> 19 <u>80</u> , and that in my <u>10</u> hour opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.        |  |                              |  |  |  |                                    |  |  |  |  |  |   |  |                                |  |                               |  |
| 22b. SIGNATURE<br><u>[Signature]</u>   |  |                              |  | DEGREE<br><u>M.D.</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |                                    |  | 22c. DATE SIGNED<br><u>11/10/19-80</u>   |  |  |  |   |  |                                |  |                               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>DR. N. SIVAN, MD.</u>  |  |                              |  | 22e. ADDRESS<br><u>CHURCH HOSPITAL CORPORATION</u><br><u>BROADWAY</u><br><u>CHURCH ST. 21231, BALTIMORE, MARYLAND</u>  |  |                                    |  |  |  |  |  |   |  |                                |  |                               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  |                              |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |   |  |                                |  |                               |  |
| BURIAL   |  |                              |  | 11/13/1980   |  | ST STANISLAUS CEMETERY             |  |  |  | BALTIMORE MARYLAND   |  |   |  |                                |  |                               |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS   |  |                              |  |  |  | 25a. DATE REC'D. BY REGISTRAR      |  | 25b. <u>[Signature]</u>  |  |  |  |   |  |                                |  |                               |  |
| DIPPEL FUNERAL HOME INC. 1800 E. LOMBARD ST.   |  |                              |  |  |  | NOV 12 1980                        |  |  |  |  |  |   |  |                                |  |                               |  |

NOV 1 1960



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

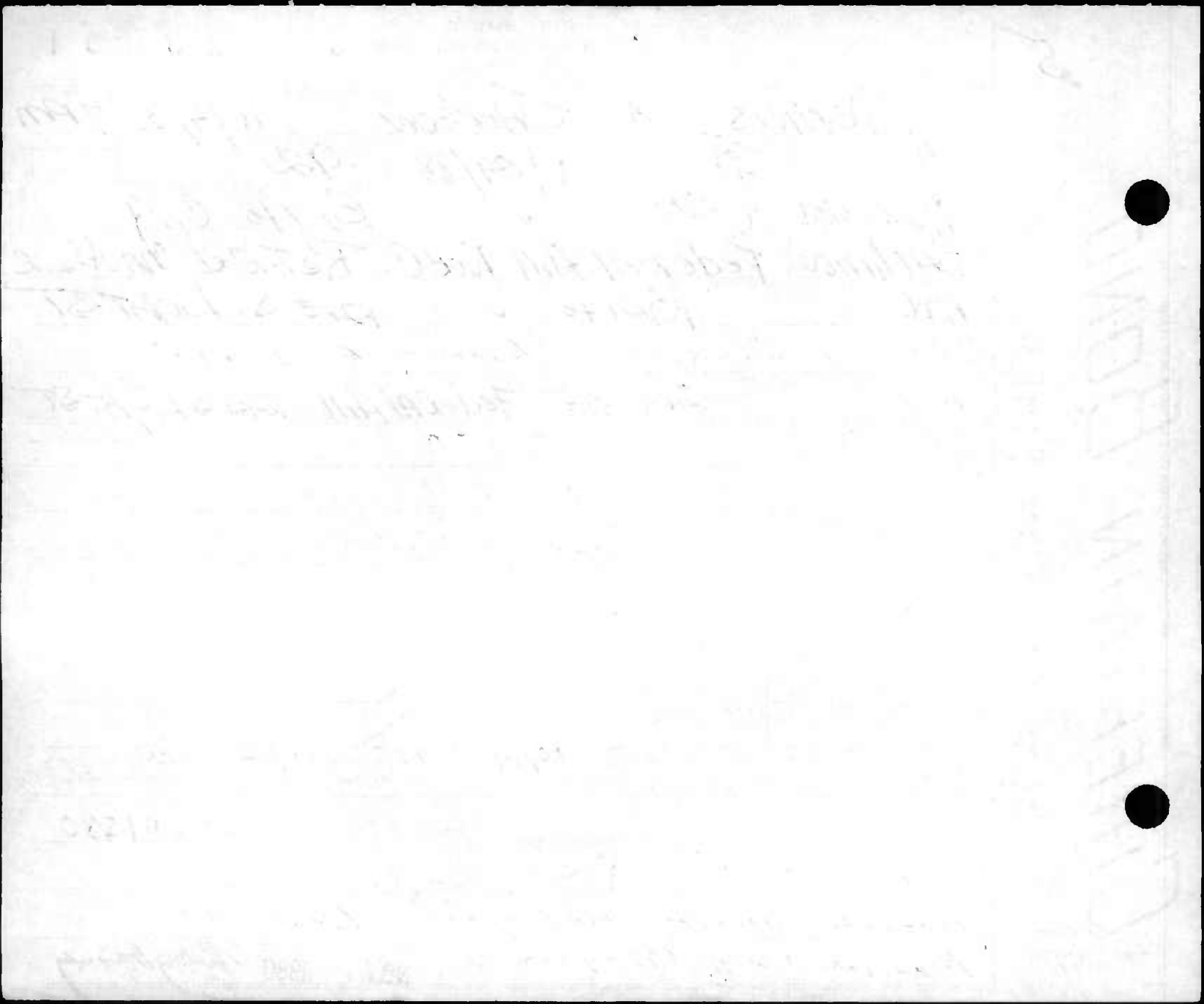
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 2 0 1

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|   |  |   |  |  |  |  |  |  |  |
|---|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>DENNIS A JACKSON</b>  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>11/4/80</b>   |  |  |  | 2b. HOUR<br><b>7 PM</b>  |  |
| 3. SEX<br><b>M</b>  |  | 4. RACE<br><b>B</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>1/29/88</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN.<br><b>92</b>   |  | 7. UNDER 1 YEAR 8. UNDER 24 HRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO CITY MD.</b>  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (GIVE FULL SUCH FACILITY, ONE STREET ADDRESS)<br><b>Federal Hill Nue.C.</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK, FORM OF EMPLOYMENT, INDUSTRY)<br><b>Retired</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Chauffeur</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>md</b>   |  | 13b. COUNTY<br><b>BALTO</b>   |  | 13c. CITY OR TOWN<br><b>BALTO</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>1213 S. Light ST</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>DENNIS JACKSON</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>ANNIS E DIXON</b>   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.<br><b>216-07-3445</b>  |  | 17. INFORMANT<br><b>Federal Hill</b>   |  | ADDRESS<br><b>1213 S Light ST</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CVA</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>CH.C.V.D. disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>2500</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes Mellitus</b> |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>7ms</b>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.<br><b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/19</b> 19 <b>77</b> to <b>11/4</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Samuel P. ...</b>  |  |   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11/5/80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Samuel P. ...</b>   |  |   |  | 22e. ADDRESS<br><b>1 Slade ...</b>   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11/8/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MAIDEN</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>BALTO MD</b>   |  |  |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br><b>Manhattan ...</b>   |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 7 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Patricia McBrady</b>  |  |





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 2 0 2

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |  |  |   |  |
|---|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>RUTH McCall JACKSON                           |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 18 80                                  |   | 2b. HOUR<br>M                            |
| 3 SEX<br>Female   | 4 RACE<br>Black   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>7 4 16  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>64 YRS.  | 7 IF UNDER 1 YEAR<br>MONTHS DAYS<br>8 IF UNDER 24 HRS<br>HOURS MIN.                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Alabama  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Balto. City MD.                           |   |  |
| 10 CITY OR TOWN OF DEATH<br>Balto.  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>401 E. 25th Street #6A |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Domestic Wk. |   | 12b. KIND OF BUSINESS OR INDUSTRY        |
| 13a. STATE<br>Md.   |   | 13b. COUNTY  | 13c. CITY OR TOWN<br>Balto.  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>401 East 25th St. |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Sam McCall  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mattie Matthews   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>Unkn. |   | 16b. SOCIAL SECURITY NO<br>434-62-2833   | 17 INFORMANT<br>ADDRESS<br>Mobile<br>Elsie Dudley 2355 Rushing Dr. Ala.          |   |  |

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4100 Acute myocardial infarction<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) coronary thrombosis<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) hypertensive cardiovascular disease<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br>Adrenal insufficiency |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>acute<br>acute<br>chronic      |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-26-80, to 11-12-80, that (I) (we) last saw the deceased alive on 10-27-80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |
| 22b. SIGNATURE<br>Ruperto Manankil   |  |  |  | 22c. DATE SIGNED<br>11-20-80   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>RUPERTO MANANKIL  |  |  |  | 22e. ADDRESS<br>6010 York Rd BALTO MD  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>11/25/80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn Cem.                          |  |
| 23d. LOCATION<br>CITY OR TOWN<br>Baltimore,  |  | COUNTY<br>M.D.   |  | 23e. DATE REC'D. BY REGISTRAR  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leroy Harris F/S 4520 Pen Lucy Rd.   |  | 25. REGISTRAR'S SIGNATURE<br>NOV 25 1980                               |  |  |  |

BP

DHHM-16 20M  
(VRA 15, 4) 7/78

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

100-100000

100-100000

100-100000

100-100000

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

2 8 2 0 3

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |   |   |  |   |  |
|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Willie Jackson</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>Nov. 15 1980</b>                              |   | 2b. HOUR<br><b>3:30 PM</b>   |
| 3. SEX<br><b>male</b>   | 4. RACE<br><b>Black</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>1 5 20</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>60</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>        |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>City</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Bon Secours</b> |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |   |   |  |   |  |
| 13a. STATE<br><b>Md.</b>  | 13b. COUNTY<br><b>City</b>  | 13c. CITY OR TOWN<br><b>Balto.</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><input checked="" type="checkbox"/>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Robert Jackson</b>   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Dalliah Jackson</b>              |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |   | 16b. SOCIAL SECURITY NO.<br><b>249-18-4873</b>  |  | 17. INFORMANT ADDRESS<br><b>Dorothy Grant 819 W. Saratogo St.</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cancer - pulmonary arrest</b><br>4360 } DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Aspiration Pneumonia</b><br>(c) <b>Cancer - Vasc. Accidents</b>  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |   |   |  |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/15</b> , 19 <b>80</b> , to <b>11/15</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>11/15</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |   |  |   |  |
| 22b. SIGNATURE<br><b>[Signature]</b>  |   | DEGREE <b>Dr. S.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   | 22c. DATE SIGNED   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>[Signature]</b>   |   | 22e. ADDRESS  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |   | 23b. DATE<br><b>11/20/80</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Zion Cem.</b>                           |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Landdown A.A. Md.</b>   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Chas. A. Rice F.S.P.A.</b> ADDRESS<br><b>1300 Eutaw Pl.</b>  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 24 1980</b>                                  |   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Page 3 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.



1038

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |   |  |   |  |   |  |  |  |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>BABY BOY JACOBS               |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>NOVEMBER 12, 1980 |   |  | 2b. HOUR<br>03:40 PM  |  |  |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>BLACK  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10/ 29/ 80  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS MONTHS DAY<br>14   |  | IF UNDER 1 YEAR<br>IF UNDER 24 HRS             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                               |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY              |  |
| 13a. STATE<br>MARYLAND   |  | 13b. COUNTY<br>BALTIMORE  |  | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>4416 OLD FREDERICK ROAD |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>DONALD JACOBS              |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>INEZ   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) |  |   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS   |  |  |  |

|   |  |  |  |  |   |  |  |  |  |
|---|--|--|--|--|---|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiorespiratory Failure</u><br>7690<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>Prematurity, Severe Hyaline Membrane Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Bronchopulmonary Dysplasia, Patent Ductus Arteriosus</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) |  |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 19a. DATE OF OPERATION<br>NOV 11 1980   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Patent Ductus Arteriosus |  |  | 20a. AUTOPSY<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)       |  | 21i. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>NOV 7</u> , 19 <u>1980</u> , to <u>NOV 12</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>NOV 12</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |   |  |  |  |  |
| 22b. SIGNATURE<br>Victor M. Santana   |  |  |  | DEGREE<br>M.D.   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>NOV 12 1980              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>VICTOR M. SANTANA  |  |  |  | 22e. ADDRESS<br>Johns Hopkins Hospital   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation   |  | 23b. DATE<br>11/13/80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Johns Hopkins Hospital                   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MD.  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS  |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE<br>NOV 25 1980  |  |  |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.







FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 2 0 5

REG. NO.

|  |  |   |   |  |  |   |  |   |  |
|--|--|---|---|--|--|---|--|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>Charles H. JACOBS</b>  |  |   | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>11/22/80</b> |  |  | 2b HOUR<br><b>550A</b> M  |  |   |  |
| 3 SEX<br><b>MALE</b>   |  | 4 RACE<br><b>Caucasian</b>  |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 15 21</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>59</b> YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY BALTIMORE</b> MD.                    |  |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL</b> |   |  |  | 12a US OCCUPATION<br>(TYPE, TRADE, OR BUSINESS)<br><b>XXXXXXXXXXXX</b>              |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>POST OFFICE</b>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE <b>MD.</b> 13b COUNTY <b>BALTO.</b> 13c CITY <b>RANDALLSTOWN</b> 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |   |  |  |   |  |   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>LOUIS JACOBS</b>   |  |   |   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>FANNIE HARRISON</b> |   |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>  |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WWII ARMY 218-07-4798</b>  |   | 17 INFORMANT<br>ADDRESS<br><b>MRS. LEAH JACOBS 9016 SAMOSET RD., RANDALLSTOWN, MD 21133</b>  |  |   |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>HYPOTENSION</b><br>4415<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>RUPTURED ANEURYSM</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |   |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |   |  |  |   |  |   |  |
| 19a DATE OF OPERATION<br><b>NA</b>   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>11/22/80</b>   |   | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>6-DBRETE BRANCH CT Timonium, Md.</b>  |  | 21g DATE SIGNED<br><b>11/22/80</b>  |  |   |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>11/16/80</b> , 19____, to <b>11/22/80</b> , 19____, that (I) (we) lost<br>saw the deceased alive on <b>11/22/80</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |   |   |  |  |   |  |   |  |
| 22b SIGNATURE<br><b>GARY HAMAMOTO MD</b>   |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |  |   |  | 22c DATE SIGNED<br><b>11/22/80</b>  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>GARY HAMAMOTO MD</b>  |  |   |   | 22e ADDRESS<br><b>6-DBRETE BRANCH CT Timonium, Md.</b>   |  |   |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b DATE<br><b>11-23-80</b>   |   | 23c NAME OF CEMETERY OR CREMATORY<br><b>PROGRESSIVE RUDOMER RUSS VEREIN</b>  |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ROSEDALE BALTO. MD</b>              |  |   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b>   |  |   |   | 25a DATE REC'D. BY REGISTRAR<br><b>NOV 25 1980</b>   |  | 25b REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                     |  |   |  |
| 26 ADDRESS<br><b>6010 REISTERSTOWN RD., BALTO., MD 21215</b>   |  |   |   |  |  |   |  |   |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

*Handwritten signature*

0891 G S VON

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 28206

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|   |  |   |   |  |                            |  |  |  |  |  |  |  |  |
|---|--|---|---|--|----------------------------|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>LOUIS S. JACOBS</i>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>NOVEMBER 18/80</i> |  | 2b. HOUR<br><i>7:10 PM</i> |  |  |  |  |  |  |  |  |
| 3 SEX<br><i>MALE</i>  |  | 4 RACE<br><i>WHITE</i>  |   | 5 DATE OF BIRTH<br><i>DEC. 25, 1896</i>  |                            | 6 AGE (IN YEARS LAST BIRTHDAY)<br><i>83</i>  |  | 7 UNDER 1 YEAR<br>MONTHS DAYS  |  | 7 UNDER 24 HRS<br>HOURS MIN.   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>RUSSIA</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><i>BALTIMORE CITY</i> MD.                         |  |  |  |  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><i>BALTIMORE</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>LEVINDALE</i> |   |  |                            | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>SELF-EMPLOYED</i> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>GROCERY</i>                                  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br><i>MARYLAND</i>  |  |   |   |  |                            | 13b. COUNTY<br><i>BALTIMORE</i>  |  | 13c. CITY OR TOWN<br><i>BALTIMORE</i>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e. STREET ADDRESS<br><i>APT. 209<br/>2500 W. BELVEDERE AVE. #21215</i> |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>JACOB VAN KELOVITZ</i>  |  |   |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>CELIA UNKNOWN</i>   |                            |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>YES</i>  |  |   |   | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br><i>WWI-ARMY 212-32-4872</i>  |                            | 17 INFORMANT<br><i>MR. IRVIN JACOBS</i><br><i>4205 FALLSTAFF RD. BALTO., MD 21215</i>    |  |  |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Septic shock</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Intestinal obstruction</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>Carcinoma of colon</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>1539</i><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>1 hour</i><br><i>1 month</i><br><i>6 months</i> |  |   |   |  |                            |  |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:   |  |   |   |  |                            |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                            |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>19</i>   |                            | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)           |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |                            | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>10/17/80</i> to <i>11/18/80</i> , that (I) (we) last saw the deceased alive on <i>11/18/80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |   |  |                            |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><i>Steven A. Levenson MD</i>  |  |   |   |  |                            | 22c. DATE SIGNED<br><i>11/18/80</i>  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>STEVEN A. LEVENSON</i>  |  |   |   |  |                            | 22e. ADDRESS<br><i>LEVINDALE - BALTO., MD 21215</i>                                      |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>BURIAL</i>   |  | 23b. DATE<br><i>11/20/80</i>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>MOGAN ABRAHAM</i>   |                            |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>ROSEDALE BALTO. MD</i>              |  |  |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><i>SOL LEVINSON &amp; BROS., INC.</i>  |  |   |   |  |                            | 25a. DATE REC'D. BY REGISTRAR<br><i>NOV 25 1980</i>                                      |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                     |  |  |  |  |  |
| 6010 REISTERSTOWN RD. BALTO., MD 21215  |  |   |   |  |                            |  |  |  |  |  |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



NOV 2 1980

*[Handwritten signature]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 2 0 7

REG. NO.

|   |  |  |  |  |   |   |  |   |  |
|---|--|--|--|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Edward C. James</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11-21-80</b> |  |   | 2b. HOUR<br><b>9:15 AM</b>  |  |   |  |
| 3. SEX<br><b>male</b>   |  | 4. RACE<br><b>white</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 11 02</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>ENGLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>      |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                                     |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. AGNES HOSPITAL</b> |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>ASSEMBLER - WEATHER INSTR.</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |   |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>BALTO</b>  |  | 13c. CITY OR TOWN<br><b>CATONSVILLE</b>  |   | 13e. STREET ADDRESS<br><b>140 HUNNERY LN, 21228</b>   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>CHARLES JAMES</b>  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>LILLIAN RING</b>                            |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>215-07-9796</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>CATHERINE V. JAMES - WIFE - AS 13C</b>  |   |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4920</b> IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ADVANCED, END STAGE EMPHYSEMA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |  |  |  |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>CONGESTIVE HEART FAILURE</b>  |  |  |  |  |   |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Nov. 19</b> , 19 <b>80</b> , to <b>Nov. 21</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>Nov. 21</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |   |  |   |  |
| 22b. SIGNATURE<br><b>W. Bradley Pifalo</b>  |  |  |  | DEGREE<br><b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |   |  | 22c. DATE SIGNED<br><b>11/21/80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>W. BRADLEY PIFALO</b>   |  |  |  | 22e. ADDRESS<br><b>ST. AGNES HOSPITAL</b>  |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>CREMATION</b>  |  | 23b. DATE<br><b>11/22/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GREEN MOUNT</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO, MD</b>  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Walter Ruth Bradley</b> ADDRESS<br><b>Baltimore, Md.</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 28 1980</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Lillian McCreedy</b>   |  |   |  |

BP

WILKINS CITY

ST. LOUIS HOTEL

ST. LOUIS

NOV 8 1908



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 2 0 8

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |   |  |   |  |   |  |
|---|--|--|---|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>John Albert James    |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 1, 1980 |   |  | 2b. HOUR<br>6:20P M   |  |   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>May 10 1918   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>62 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>North Carolina |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                    |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Maryland General Hospital |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Insurance Agent-Insurance |  | 12b. KIND OF BUSINESS OR INDUSTRY         |  |

|   |  |  |  |  |  |  |   |  |  |  |
|---|--|--|--|--|--|--|---|--|--|--|
| 13a. STATE<br>Md.   |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore                                   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>26 E. Mount Vernon Ave. |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Morrison James                    |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Singleward |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>W.W. II |  | 17. INFORMANT<br>Sara James                                      |  |   | ADDRESS<br>Glen Burnie 21061<br>4 Roosevelt Ave. |  |  |

|   |  |   |  |
|---|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br>1991 Metastatic Undifferentiated Carcinoma of Unknown Primary<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
|---|--|---|--|

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION<br>7-17-80  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Metastasis to Right Parietal lobe of brain requiring a craniotomy for its removal |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (x) (this hospital) attended the deceased from July 1, 1980 to November 1, 1980, that (x) (we) lost the deceased alive on November 1, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did not) view the body after death. |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br>James C. Cockey  |  |   |  | DEGREE<br>M.D.<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>11/2/80   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>James Cockey M.D.   |  |   |  | 22e. ADDRESS<br>Care of Maryland General Hospital   |  |   |  |

|   |  |                      |  |   |  |  |  |
|---|--|----------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation |  | 23b. DATE<br>11/4/80 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Memorial Pk. |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Md. |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>George J. Gonce           |  |                      |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 5 1980                 |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]                    |  |

(M)

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 11-11-2003 BY 60322 JAL/STP

James Earl Ray  
born January 5, 1928  
Tomball, Texas  
Ray was a member of the  
Black Panther Party and  
was involved in the  
assassination of Dr. Martin Luther King Jr.  
on April 4, 1968.  
Ray was arrested on January 16, 1969,  
and was charged with the murder of King.  
He was found guilty and sentenced to  
99 years in prison.  
Ray was paroled in 1972 and fled to  
Europe, where he lived for several years.  
He was arrested again in 1975 and  
sentenced to life in prison.  
Ray died of a heart attack in 1998.  
His remains were buried in Scotland.

James Earl Ray  
born January 5, 1928  
Tomball, Texas  
Ray was a member of the  
Black Panther Party and  
was involved in the  
assassination of Dr. Martin Luther King Jr.  
on April 4, 1968.  
Ray was arrested on January 16, 1969,  
and was charged with the murder of King.  
He was found guilty and sentenced to  
99 years in prison.  
Ray was paroled in 1972 and fled to  
Europe, where he lived for several years.  
He was arrested again in 1975 and  
sentenced to life in prison.  
Ray died of a heart attack in 1998.  
His remains were buried in Scotland.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

28209

FOR  
1- STATE  
REGISTRAR

|  |                         |   |  |   |   |   |  |
|--|-------------------------|---|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Lewis S. James</b>   |                         |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>MONTH <b>11</b> DAY <b>23</b> YEAR <b>1980</b> |   |   | 2b. HOUR<br><b>2:48</b> AM  |  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>Black</b> | 5. DATE OF BIRTH<br>MONTH <b>6</b> DAY <b>8</b> YEAR <b>40</b>  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br><b>40</b> YRS.                                 | IF UNDER 1 YR.<br>MONTHS _____ DAYS _____   | IF UNDER 24 HRS.<br>HOURS _____ MIN _____                     | 2c. DATE PRONOUNCED DEAD<br>MONTH <b>11</b> DAY <b>23</b> YEAR <b>1980</b>                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sinai Hospital</b> |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |   | 12b. KIND OF BUSINESS OR INDUSTRY            |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |                         |   |  |   |   |   |  |
| 13a. STATE<br><b>MD</b>  |                         | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST <b>William</b> MIDDLE _____ LAST <b>James</b>   |                         |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Dora</b> MIDDLE _____ LAST <b>Wooden</b>   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>   |                         | 16b. SOCIAL SECURITY NO.<br><b>218-36-2779</b>  |  | 17. INFORMANT ADDRESS<br><b>Linda M. James 4801 Beaufort Ave.</b>   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>Smoke Inhalation</b><br>IMMEDIATE CAUSE (a) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: _____<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>(c) _____  |                         |   |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |                         |   |  |   |   |   |  |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>2:00xx 11 23 1980</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Subject caught in house fire</b>  |   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>  |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>home</b>  |  | 21f. LOCATION<br>STREET <b>4801 Beaufort Ave.,</b> CITY OR TOWN <b>Baltimore</b> COUNTY _____ STATE <b>Md.</b>  |   |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                         |   |  |   |   |   |  |
| ACTUAL SIGNATURE<br><i>Virginia L. Dolan</i>   |                         | TITLE (SPECIFY)<br><b>Assistant</b>   |  | DATE SIGNED<br><b>11/23/80</b>  |   | MEDICAL EXAMINER  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Virginia L. Dolan, M.D.</b>   |                         | ADDRESS<br><b>111 Penn Street</b>   |  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |                         | 23b. DATE<br><b>11/29/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn Cem.</b>  |   | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore</b> COUNTY _____ STATE <b>MD</b>                     |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>  |                         | ADDRESS<br><b>1101 E. North Ave.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 25 1980</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |

BP



NOV 5 1980

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 2 1 0

REG. NO.

|   |  |  |  |   |  |   |   |   |   |
|---|--|--|--|---|--|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>STEPHEN JOSEPH JANKIEWICZ  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>NOV. 1 80                       |   |  | 2b. HOUR<br>8:00 A.M.   |   |   |   |
| 3. SEX<br>MALE  |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>MAY 26 1909   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71   |   | 7. UNDER 1 YEAR<br>IF UNDER 24 HRS<br>MONTHS DAYS HOURS MIN.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO. CITY. MD.  |   |   |   |
| 10. CITY OR TOWN OF DEATH<br>BALTO.   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>127 S. CASTLE ST. |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>LABORER                     |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>ESTKAY MTS.  |   |
| 13a. STATE<br>md  |  | 13b. COUNTY<br>CITY  |  | 13c. CITY OR TOWN<br>BALTO  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br>127 S. CASTLE ST.  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>FRANK JANKIEWICZ  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>CATHERINE   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO  |  |   |   |   |   |
| 16b. SOCIAL SECURITY NO.<br>213-01-3470   |  | 17. INFORMANT<br>ADDRESS<br>127 S. CASTLE ST. BALTO. MD. 21231   |  |   |  |   |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease<br>4140<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |   |  |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>year |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |  |  |   |  |   |   |   |   |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |   |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |   |   |
| 22a. I certify that (i) this hospital attended the deceased from Nov 1 1980, to Nov 1 1980, that (ii) we lost saw the deceased alive on above (i) (we) did not see the body after death.  |  |  |  |   |  |   |   |   |   |
| 22b. SIGNATURE<br>Robert E. Stoner  |  |  | DEGREE   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   | 22c. DATE SIGNED<br>11-1-80   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Robert E. Stoner   |  |  | 22e. ADDRESS<br>714 York Rd. Towson 21204                              |   |  |   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  |  | 23b. DATE<br>NOV. 4, 1980  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>HOLY ROSARY CEM.   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO. BALTO. MD. |   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>WM. FIALKOWSKI  |  |  | ADDRESS<br>2007 EASTERN AVE.   |   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 3 1980   |   | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |   |

100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 2 1 1

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|   |  |   |   |   |   |  |  |  |
|---|--|---|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Carrie Margaret Jendrek  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 11, 1980        |   |   | 2b. HOUR<br>6:30 P.M.  |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Caucasian  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>June 10, 1905   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>75 YRS.                             |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.             |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Bon Secours Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Key Punch Operator  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Data Proc.                        |  |  |
| 13a. STATE<br>Maryland  |  |   | 13b. COUNTY<br>Baltimore  |   | 13c. CITY OR TOWN<br>Catonsville  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George Heinmuller   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Margaret Lober |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>N/A  |   | 17. INFORMANT<br>ADDRESS<br>2113 Mt Hebron Dr.<br>Mr. Richard A. Jendrek Ellicott City, Md.   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u><br>4292 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Artery Disease</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 hrs |  |   |   |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):  |  |   |   |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |  |  |  |
| 21d. INJURY OCCURRED<br>AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost<br>saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (I) (we) (did not) view the body after death.                                       |  |   |   |   |   |  |  |  |
| 22b. SIGNATURE<br>J. Nelson McKay   |  |   |   | DEGREE<br>M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |   | 22c. DATE SIGNED<br>11/12/80   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>J. Nelson McKay, M.D.  |  |   |   | 22e. ADDRESS<br>1132 N. Rolling Rd. Balt., Md. 21228  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>11/14/80   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Redeemer   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore City, Maryland |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>MacNabb Funeral Home  |  |   |   | ADDRESS<br>Catonsville, Md.   |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 17 1980                           |  |  |

BP

DHMH-16 25M  
(VRA 15, 4) 1/79

113 8.2 11.4

113 8.2 11.4



*[Faint, illegible handwritten text covering the middle section of the page]*

*[Faint, illegible handwritten text at the bottom of the page]*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 2 1 2

1 - FOR  
STATE  
REGISTRAR

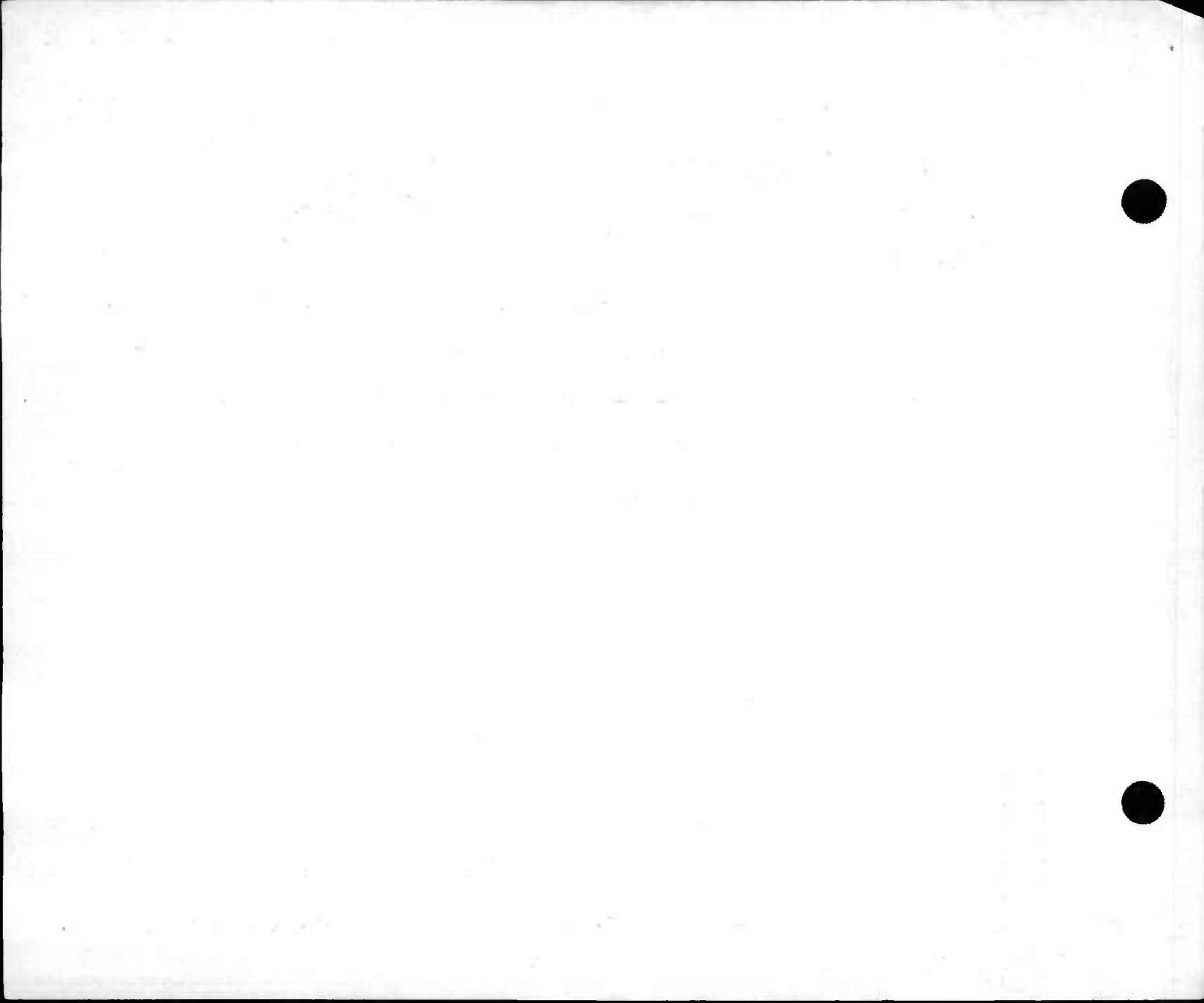
REG. NO.

|  |   |  |   |   |  |
|--|---|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>EMMA JENKINS   |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11-5-80  |   | 2b. HOUR?<br>7:15 AM   |
| 3 SEX<br>Female  | 4 RACE<br>Black   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>12 2 01   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>78 YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>S. Carolina   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.  | MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. BALTIMORE CITY OR COUNTY OF DEATH<br>City MD.  |   |  |
| 10 CITY OR TOWN OF DEATH<br>Balto.   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired                     | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |   |  |   |   |  |
| 13a. STATE<br>Maryland   | 13b. COUNTY   | 13c. CITY OR TOWN<br>Baltimore   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>308 S. Catherine St.                               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Steven Jenkins   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Rebecca Paco  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   | (IF YES, GIVE WAR OR DATES)   | 16b. SOCIAL SECURITY NO<br>249-05-4703   | 17 INFORMANT<br>ADDRESS<br>Mildred Phillips 304 S. Catherine St.                                |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest + Cardiac shock</u> - hours<br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <u>Acute myocardial infarction</u> hours<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>1788000 - cold</u> years |   |  |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |   |  |   |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11:05</u> 19 <u>80</u> to <u>11:05</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>11:05</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |   |  |   |   |  |
| 22b. SIGNATURE<br><u>Dr. [Signature]</u>   |   | DEGREE<br><u>MD</u>  |   | 22c. DATE SIGNED<br>11-05-80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MARCO ANTONIO R. ARBUERNE   |   | 22e. ADDRESS<br>1540 W. Balto ST Balto Md 21223  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  | 23b. DATE<br>11-11-80   | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. (Westport) Md.                             | 25a. DATE REC'D. BY REGISTRAR<br>NOV 7 1980                               |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Chas. A. Rice FSPA 1300 Eutaw Pl.  |   |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

54

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 2 1 3

REG. NO.

|   |  |  |  |  |                                      |  |  |
|---|--|--|--|--|--------------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>LEWIS BROWN JENKINS</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 30 80</b> |  | 2b. HOUR<br><b>8:25a<sub>M</sub></b> |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>BLACK</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 9 10</b>  |                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS.<br>IF UNDER 1 YEAR: MONTHS DAYS<br>IF UNDER 24 HRS: HOURS MIN.           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY,</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VETERANS ADMINISTRATION MEDICAL CENTER</b> |  |  |                                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |                                      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>WILLIAM JENKINS</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>FLORENCE GROSS</b>   |  | 17. INFORMANT ADDRESS<br><b>VAMC Clinical Records 3900 LOCH RAVEN BLVD</b>   |                                      |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>217015086</b>   |  | 17. INFORMANT ADDRESS<br><b>VAMC Clinical Records 3900 LOCH RAVEN BLVD</b>   |                                      |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pulm Thrombemboli</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Ca of Liver + Rt Lung</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>1991</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.       |  |  |  |  |                                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):   |  |  |  |  |                                      |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |                                      |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                                      |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>NOVEMBER 17</u> , 19 <u>80</u> , to <u>NOVEMBER 30</u> , 19 <u>80</u> , that (we) last saw the deceased alive on <u>NOVEMBER 30</u> , 19 <u>80</u> , and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(I)</u> (we) (did) (did not) view the body after death. |  |  |  |  |                                      |  |  |
| 22b. SIGNATURE<br><u>D. Schreiner M.D.</u>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |                                      | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>P. Schreiner</u>  |  |  |  | 22e. ADDRESS<br><b>3900 LOCH RAVEN BLVD 21218</b>  |                                      |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>12/5/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Garden of Eternal Hope</b>  |                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Westminster MD</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>WILLIAM C. MARCH FUNERAL HOME INC.</b>   |  |  |  | 25a. DATE RECD. BY REGISTRAR<br><b>DEC 2 1980</b>  |                                      | 25b. REGISTRAR'S SIGNATURE<br><u>Patricia Hebrudy</u>  |  |

MEDICAL CERTIFICATION

9 9

1

1723 BP

100:5 00 00 00

70

10

100:5 00 00 00

U.S.A.

100:5 00 00 00

100:5 00 00 00

100:5 00 00 00

100:5 00 00 00

100:5 00 00 00

100:5 00 00 00

100:5 00 00 00

100:5 00 00 00

100:5 00 00 00

100:5 00 00 00

100:5 00 00 00

100:5 00 00 00

100:5 00 00 00

100:5 00 00 00

100:5 00 00 00

100:5 00 00 00

100:5 00 00 00

100:5 00 00 00

100:5 00 00 00

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |  |  |   |  |  |  | 80 28214                                     |  |
|---|--|---|--|--|--|---|--|--|--|--|--|
| 1 - FOR STATE REGISTRAR   |  |   |  |  |  |   |  |  |  | REG. NO.                                     |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Margaret R JENKINS</b>   |  |   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 - 16 - 80</b>                                      |  | 2b. HOUR<br><b>3 P. M.</b>   |  |  |  |
| 3. SEX<br><b>F</b>  |  | 4. RACE<br><b>W</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 1 24</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>56</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>City</b> MD.   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>CHURCH HOSP</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HSWR</b>                 |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13a. STATE<br><b>MD.</b>  |  | 13b. COUNTY<br><b>BALTO</b>   |  | 13c. CITY OR TOWN<br><b>DUNDALK</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>7235 MARTELL AVE</b>   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOSEPH BETTINELLI</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>KILHEMIA ANNARELLI</b>   |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>216 16024</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>JAMES B JENKINS ABOVE</b>   |  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiogenic shock</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Myocardial Infarction Vent Arrhythmia</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |   |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>COPD Hypertension</b>  |  |   |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>none</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>—</b>  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>Church Hospital</b>  |  |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/15/80</b> , 19 <b>80</b> , to <b>11/16/80</b> , 19 <b>80</b> , that (I) (we) lost<br>saw the deceased alive on <b>11/16/80</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                  |  |   |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>M. T. A. Qi</b>  |  |   |  | DEGREE <b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br><b>11/16/80</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>M. TAQI</b>   |  |   |  | 22e. ADDRESS<br><b>Church Hospital 21271</b>   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>11/19/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ST. STANISLAUS</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. MD.</b>                                 |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>J.G. CONNELLY 300 MACE</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 20 1980</b>  |  |   |  |  |  |  |  |

0891 0 5 VOF

*[Handwritten signature]*



3

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 2 8 2 1 5

REG. NO.

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>RICHARD G. JENKINS   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11-5-80   |  | 2b. HOUR<br>2:50 AM  |
| 3. SEX<br>MALE  | 4. RACE<br>CAUCASIAN   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>JUNE 24 1936  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>44 YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD.  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                           |  |
| 10. CITY OR TOWN OF DEATH<br>BALTO.   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>CHURCH HOSPITAL CORP. |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>CARPENTER  | 12b. KIND OF BUSINESS OR INDUSTRY<br>-   |  |
| 13a. STATE<br>MD.   |  |   | 13b. COUNTY<br>BALTO.  | 13c. CITY OR TOWN<br>BALTO.  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>ALLIE L. JENKINS  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MADELINE PFISTER  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>219-32-1254  |  | 17. INFORMANT<br>ADDRESS<br>10129 FONTAINE DR.<br>MIDGE KALENDEK (SISTER) 21234      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ACUTE MYOCARDIAL INFARCTION</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d) _____ |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10-9</u> , 19 <u>80</u> , to <u>11-5</u> , 19 <u>80</u> , that (I) (we) lost<br>saw the deceased alive on <u>11-5</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |
| 22b. SIGNATURE<br>Winston Hugh Williams M.D.  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>11/5/80  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>WINSTON HUGH WILLIAMS, M.D.  |  |   | 22e. ADDRESS<br>CHURCH HOSPITAL CORPORATION 21231<br>600 NORTH BROADWAY, BALTIMORE, MARYLAND   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>11/6/80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>May's Chapel                                   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Towson, Md.   |  | 23e. DATE REC'D. BY REGISTRAR<br>NOV 5 1980   |  |  |  |
| 24. FUNERAL HOME<br>Home, Inc.  |  | 25. REGISTRAR'S SIGNATURE<br>Anthony Delaney  |  |  |  |

35  
34  
35  
300  
1

MEDICAL CERTIFICATION

2  
9

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

2719



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 2a. DATE OF DEATH  |  | 2b. HOUR   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | 3. SEX   |  | 5. DATE OF BIRTH   |  |
| STANLEY S. JENKINS   |  | MALE   |  | 13 1912  |  |
| 2. RACE  |  | 6. AGE   |  | 7. BALTIMORE CITY OR COUNTY OF DEATH                     |  |
| Caucasian  |  | 69   |  | BALTIMORE  |  |
| 8. BIRTHPLACE  |  | 9. CITIZEN OF WHAT COUNTRY?  |  | 10. USUAL OCCUPATION                                     |  |
| MD   |  | U.S.A.   |  | Maintenance-Hospital                                     |  |
| 11. CITY OR TOWN OF DEATH  |  | 12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION  |  | 13. USUAL RESIDENCE                                      |  |
| BALTIMORE  |  | South H Baltimore General  |  | MD   |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  | 16. SOCIAL SECURITY NO.                                  |  |
| James P. JENKINS   |  | Fannie JORDAN  |  | 215-24-3228  |  |
| 17. WAS DECEASED EVER IN U.S. ARMED FORCES?  |  | 18. INFORMANT  |  | 19. ADDRESS  |  |
| Yes  |  | Mr. Harry P. Jenkins   |  | 1904 Cedar Rd. 21122                                     |  |
| 20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |
| PART 1. DEATH WAS CAUSED BY:   |  |  |  |  |  |
| IMMEDIATE CAUSE (a) Cardio Pulmonary arrest  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |
| (b)  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |
| (c)  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |
| 21a. DATE OF OPERATION   |  | 21b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 21c. AUTOPSY?  |  |
|  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21d. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                        |  | 21e. TIME OF INJURY  |  | 21f. HOW INJURY OCCURRED                                 |  |
| (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | HOUR A.M. MONTH DAY YEAR   |  | (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |  |
|  |  | P.M. 19  |  |  |  |
| 21g. INJURY OCCURRED   |  | 21h. PLACE OF INJURY   |  | 21i. LOCATION  |  |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | CITY OR TOWN COUNTY STATE                                |  |
| 22. I certify that (I) (this hospital) attended the deceased from 11/04/80 19 80, to 11/12 19 80, that (I) (we) lost                 |  |  |  |  |  |
| saw the deceased alive on 11/12 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated |  |  |  |  |  |
| 22a. SIGNATURE   |  | DEGREE   |  | 22c. DATE SIGNED   |  |
| Sander L. Howard MD  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 11/12/80   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |  |  |
| Sander L. Howard   |  | 300, S. HANOVER ST.  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY                       |  |
| Burial   |  | 11/13/80   |  | Cedar Hill Cemetery                                      |  |
| 23d. LOCATION  |  | 23e. CITY OR TOWN  |  | 23f. COUNTY  |  |
| BALTIMORE  |  | BALTIMORE  |  | ANNE ARUNDEL MD  |  |
| 24. FUNERAL DIRECTOR   |  | 24a. NAME  |  | 24b. ADDRESS   |  |
| Mc Cully Funeral Home of Curtis Bay  |  | 4200 Pennington Avenue Balto., Md. 21226   |  | NOV 12 1980  |  |

0 1 2 3 4 5 6 7 8 9

UNITED STATES DEPARTMENT OF THE ARMY  
OFFICE OF THE CHIEF OF STAFF  
WASHINGTON, D. C.

7

MEMORANDUM FOR THE CHIEF OF STAFF  
SUBJECT: [Illegible]

XX

PO

XX

XX

XX

(1)

[Illegible]

[Illegible]

DATE:

[Illegible]

[Illegible]

- - -

(2)

[Illegible]

20

[Illegible]

NOV 15 1940

[Illegible]

[Illegible]



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE FILES AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                         |   |   |   |  |  |  |   |  | REG. NO. 28217  |  |
|---|-------------------------|---|---|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Blanche Jennings</b>   |                         |   |   |   |  |  |  |   |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> HOUR <input type="checkbox"/> MIN. <b>11 15 19 80</b> |  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>Black</b> | 5. DATE OF BIRTH<br>MONTH <b>2</b> DAY <b>12</b> YEAR <b>98</b>   | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) <b>82</b> YRS. | IF UNDER 1 YR.<br>MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>                | IF UNDER 24 HRS.<br>MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN. <input type="checkbox"/> | 2c. DATE PRONOUNCED DEAD <b>11 15 19 80</b>  |  | 2d. HOUR <b>5:55</b> P.M.                                       |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                            |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>4416 Wrenwood Avenue</b> |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY                               |  |   |  |
| 13a. STATE<br><b>Maryland</b>   |                         | 13b. COUNTY   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>202 n. Payson Street</b>              |  |   |  |
| 14. FATHER'S NAME<br>FIRST <b>James</b> MIDDLE <b>Nelson</b> LAST <b>Nelson</b>   |                         |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Sophia</b> MIDDLE <b>Johnson</b> LAST <b>Johnson</b>   |  |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>No</b>   |                         | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT ADDRESS<br><b>Vivian Floyd 1935 W. North Avenue</b>   |  |  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY: <b>Arteriosclerotic Cardiovascular Disease</b><br>IMMEDIATE CAUSE (a) <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.</b><br>(c) DUE TO, OR AS A CONSEQUENCE OF   |                         |   |   |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |                         |   |   |   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |   |  |  |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |                         |   |   |   |  |  |  |   |  |   |  |
| ACTUAL SIGNATURE <b>Margarita A. Korell</b>   |                         |   |   | TITLE (SPECIFY) <b>Assistant</b> MEDICAL EXAMINER   |  |  |  | DATE SIGNED <b>11-16-80</b>                                     |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>  |                         |   |   | ADDRESS <b>111 Penn Street</b>  |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |                         | 23b. DATE <b>11/21/80</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY <b>Mount Calvary</b>   |  |  |  | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore</b> COUNTY <b>MD</b> |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>WILLIAM C. MARCH FUNERAL HOME INC.</b><br>ADDRESS <b>1101 E. North Avenue</b>   |                         |   |   | 25a. DATE REC'D. BY REGISTRAR <b>NOV 19 1980</b>  |  |  |  | 25b. REGISTRAR'S SIGNATURE <b>Ricky Kelly</b>                   |  |   |  |



10-10-10 10-10-10 10-10-10 10-10-10 10-10-10

\_\_\_\_\_

\_\_\_\_\_



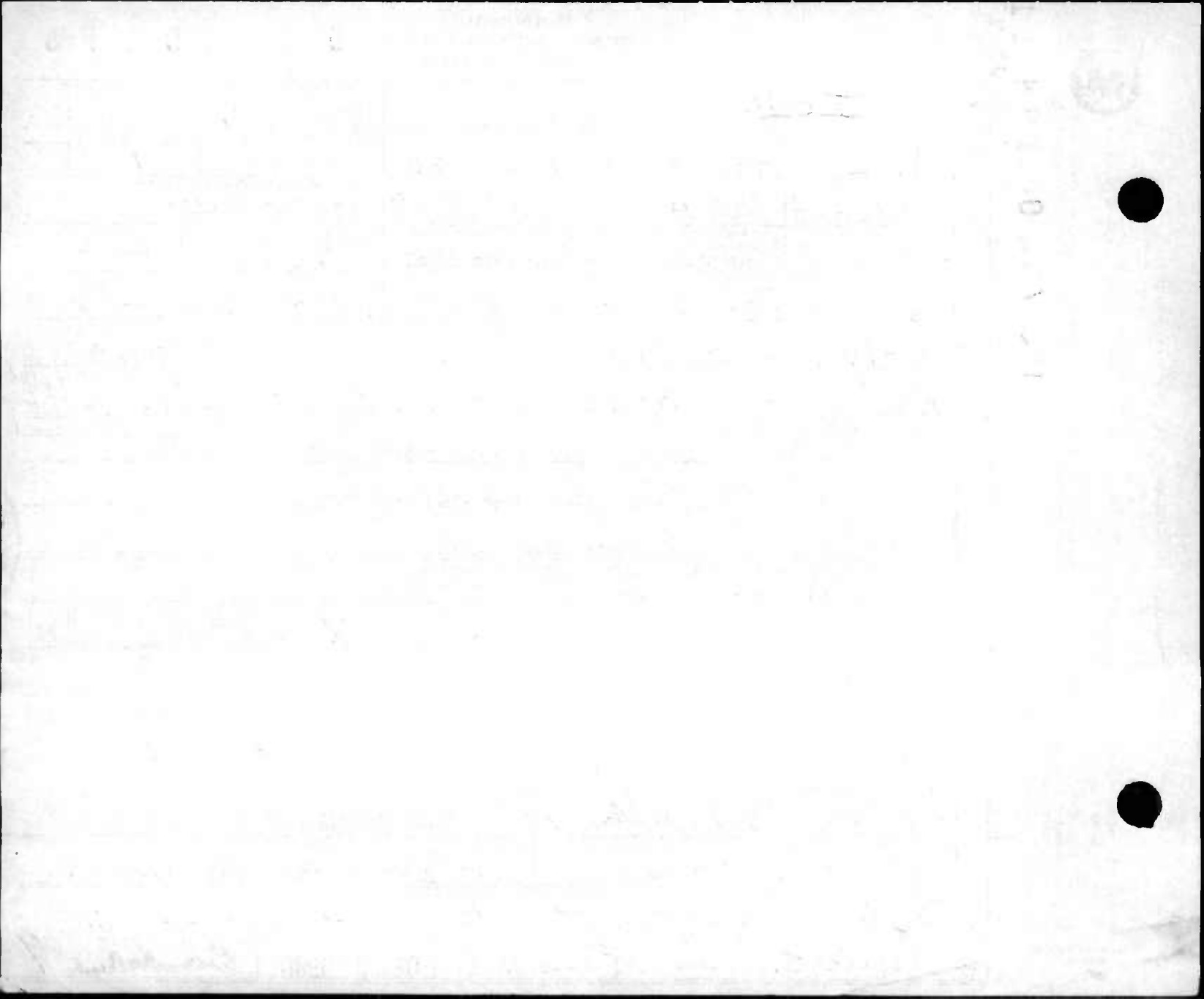
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 28218

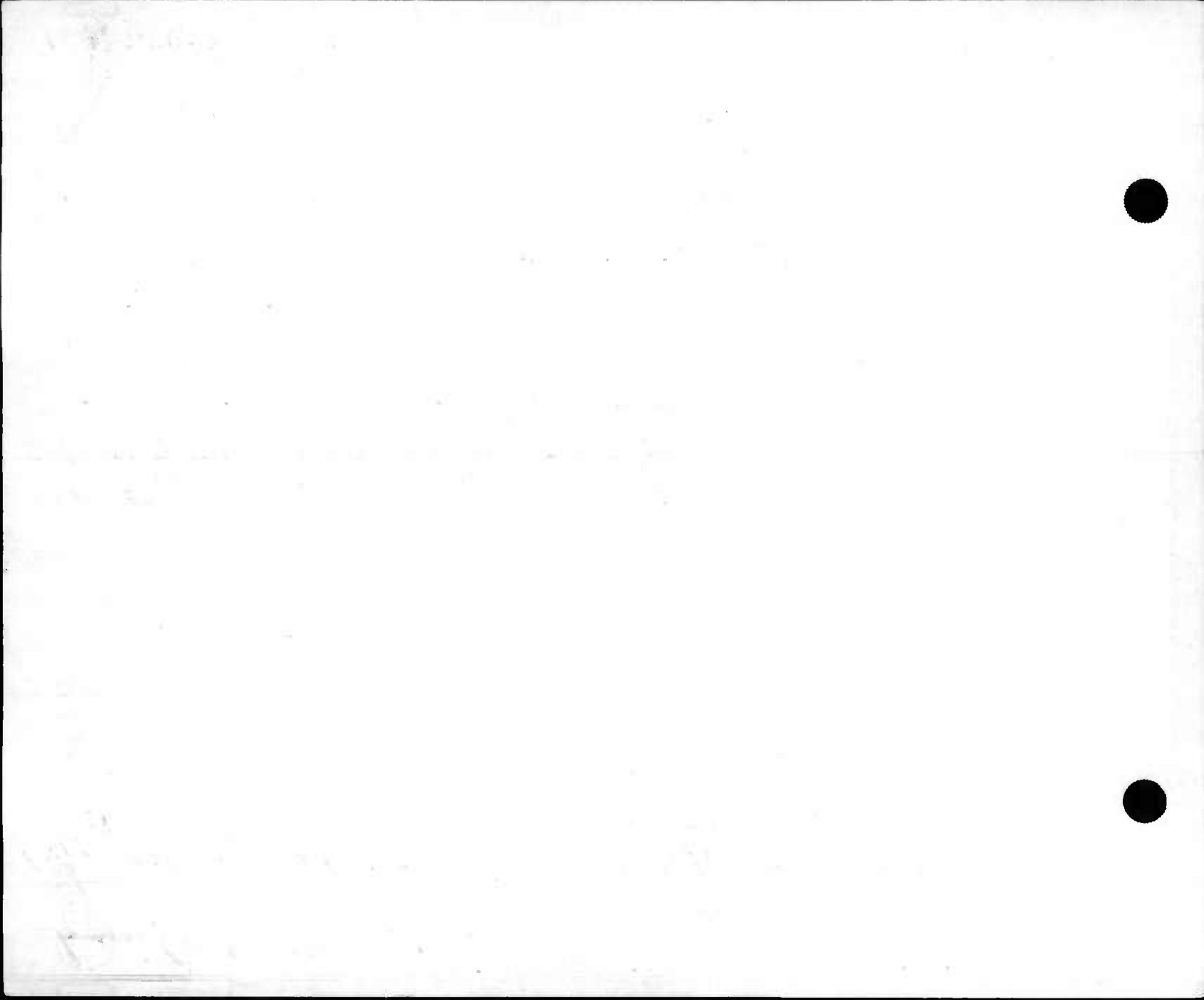
REG. NO.

|   |  |  |  |   |  |  |   |   |  |  |
|---|--|--|--|---|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JOHN</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>October 24, 1980</b>   |   |  | 2b. HOUR<br><b>01:18 PM</b>  |   |   |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>AFRICAN</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 23 80</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>1</b>  |   | IF UNDER 1 YEAR<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>The Johns Hopkins Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>NONE</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD</b> 13b. COUNTY <b>AA</b> 13c. CITY OR TOWN <b>CO GLEN BURNIE</b>  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 13e. STREET ADDRESS<br><b>6924 Ritchie Hwy</b>                                 |  |   |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Jocelyn - Belu John</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Eunice Slowe</b>   |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |   |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>NONE</b> |  |
| 17. INFORMANT<br>ADDRESS<br><b>Jocelyn Belu John - 6924 Ritchie Hwy</b>   |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Severe Asphyxia Neonatorum</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Microscopic Aspiration</b> |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Intractable seizures</b>  |  |  |  |   |  |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/23</b> , 19 <b>80</b> , to <b>10/24</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>10/24</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |   |   |  |  |
| 22b. SIGNATURE<br><b>Richard A. Molteni</b>   |  |  | DEGREE<br><b>MD</b>  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RICHARD A. MOLTONI</b>  |  |  | 22e. ADDRESS<br><b>JOHNS HOPKINS HOSP. BALTIMORE MD.</b>   |   |  |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>  |  |  | 23b. DATE<br><b>10/27/80</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St Rest</b>                           |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Harmon AA MD</b> |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wmell B. Oden</b>  |  |  | ADDRESS<br><b>Balto. Md.</b>   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 3 1980</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Robert A. Brady</b>  |  |  |

MEDICAL CERTIFICATION







TO HOSPITAL AND ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 8029220  |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>JAMES Oliver Forest Johns</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>Nov. - 7 - 80</b>                             |  |  |  |
| 3 SEX <b>male</b>  |  |  |  | 4 RACE <b>white</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 6 41</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA USA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>39</b> YRS.                                    |  | 8. IF UNDER 1 YEAR MONTHS DAYS   |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University of Maryland</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.                    |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>State of Md.</b>  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Carpenter</b>   |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>State of Md.</b>                             |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b> 13a. COUNTY <b>AnneArundele</b> 13c. CITY OR TOWN <b>Glen Burnie</b> 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  | 13b. STREET ADDRESS <b>205 Glen Road</b>  |  |  |  |
| 14. FATHER'S NAME (FATHER) <b>Juan P. Johns</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME (MOTHER) <b>MARY Williams</b>                            |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) <b>Yes Vietnam</b>   |  |  |  | 16b. SOCIAL SECURITY NO. <b>219.38.7629</b>                                       |  |  |  |
| 17. INFORMANT ADDRESS <b>Mrs. Cynthia L. Johns Wife</b>  |  |  |  | 17. INFORMANT ADDRESS <b>Same as 13</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Disseminates Herpes Simplex</b><br>0549<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hodgkins Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Preleukemia</b>  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10-10-80</b> 19 <b>80</b> , to <b>11-7</b> 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>11-7</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |
| 22b. SIGNATURE <b>Sidney Crain MD</b> DEGREE   |  |  |  | 22c. DATE SIGNED <b>11-7-80</b>   |  | 22d. ADDRESS <b>BCRP 23 S. Greene St.</b>  |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SIDNEY M. CRAIN MD</b>  |  |  |  | 22f. ADDRESS <b>BCRP 23 S. Greene St.</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  | 23b. DATE <b>Nov 11, 80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Lake View Mem. Park</b>                     |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Sykesville Maryland</b>   |  |
| 24. FUNERAL DIRECTOR NAME <b>Singleton Funeral Home</b> ADDRESS <b>Glen Burnie Md.</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>NOV 10 1980</b>                                  |  |  |  |

BP

0021

1

PE

U. S. DEPT. OF JUSTICE

Attorney General

Washington, D. C.



RECEIVED

1950

John Edgar Hoover

Director, Federal Bureau of Investigation

Washington, D. C.

Very truly yours,

John Edgar Hoover

*[Handwritten signature]*

W. H.

ASST. DIR.

AD. AD.

100-100000

100-100000



NOV 10 1950

11



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

2 8 2 2 1

1. FOR  
STATE  
REGISTRAR

REG. NO.

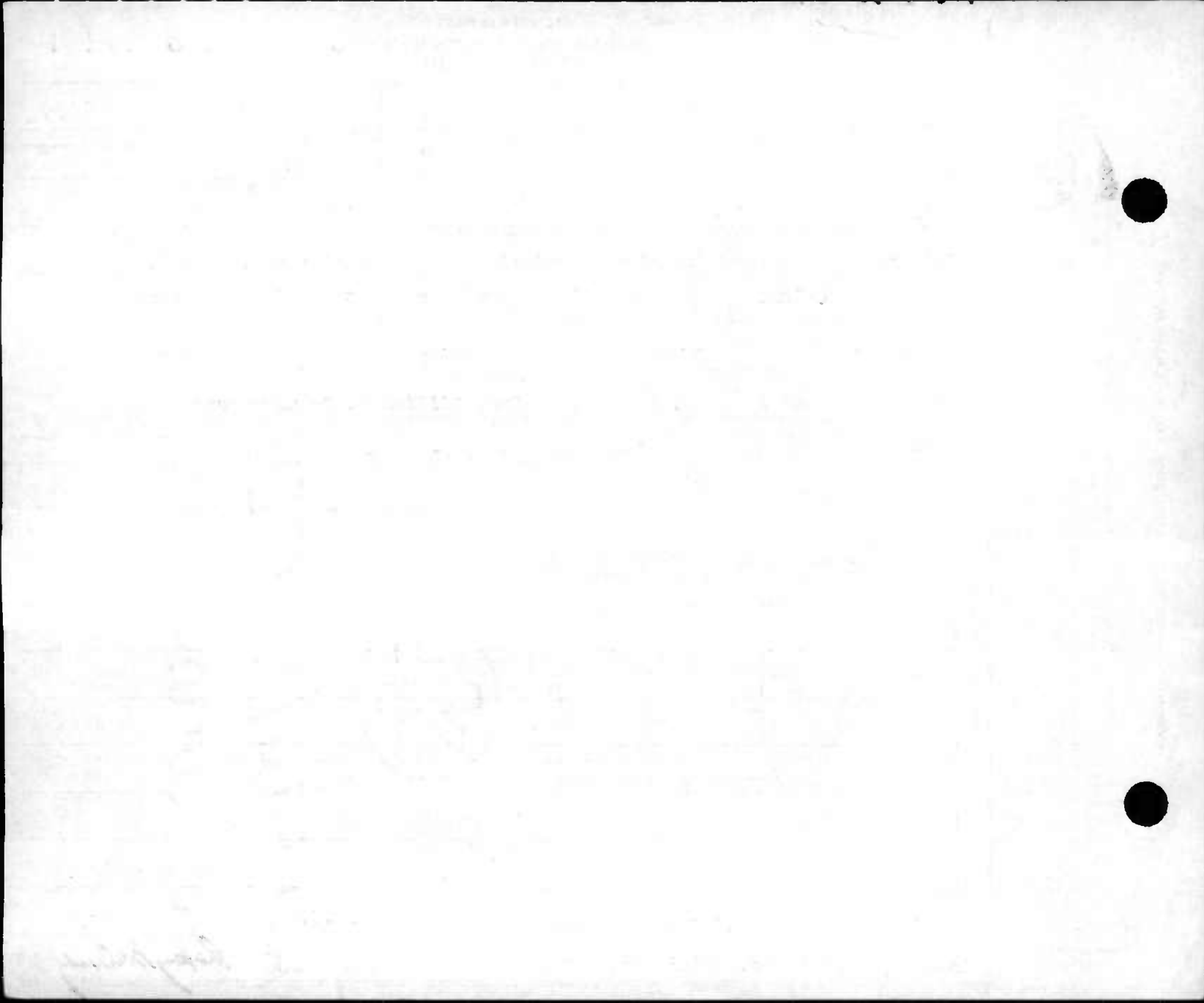
|   |   |   |   |  |  |
|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Behigamin F. Johnson   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 30 80   |  | 2b. HOUR<br>11:58 M  |
| 3. SEX<br>Male  | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 13 08  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Virginia  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>City MD.  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NONE IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Good Samaritan Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Engineer B. & O. R.R. |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>Md. State   | 13b. CITY OR TOWN<br>Baltimore  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  | 13d. ADDRESS<br>3006 Linwood Avenue   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Robert Johnson  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Daisy Royster  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>yes   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WW 2   | 17. INFORMANT<br>ADDRESS<br>Mrs. Lillian L. Johnson same  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest</u><br><u>4275</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |   |   |   |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death.                                     |   |   |   |  |  |
| 22b. SIGNATURE<br><u>Richard Nora</u>   |   | DEGREE<br>no  |   | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>RICHARD NORA   |   | 22e. ADDRESS<br>GOOD SAMARITAN HOSP.  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  | 23b. DATE<br>Dec. 3, 1980   | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md.                               | 25a. DATE REC'D. BY REGISTRAR<br>DEC 2 1980                                    |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Leonard J. Ruck Inc. Baltimore, Maryland  |   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Richard Nora</u>   |  |  |

9

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

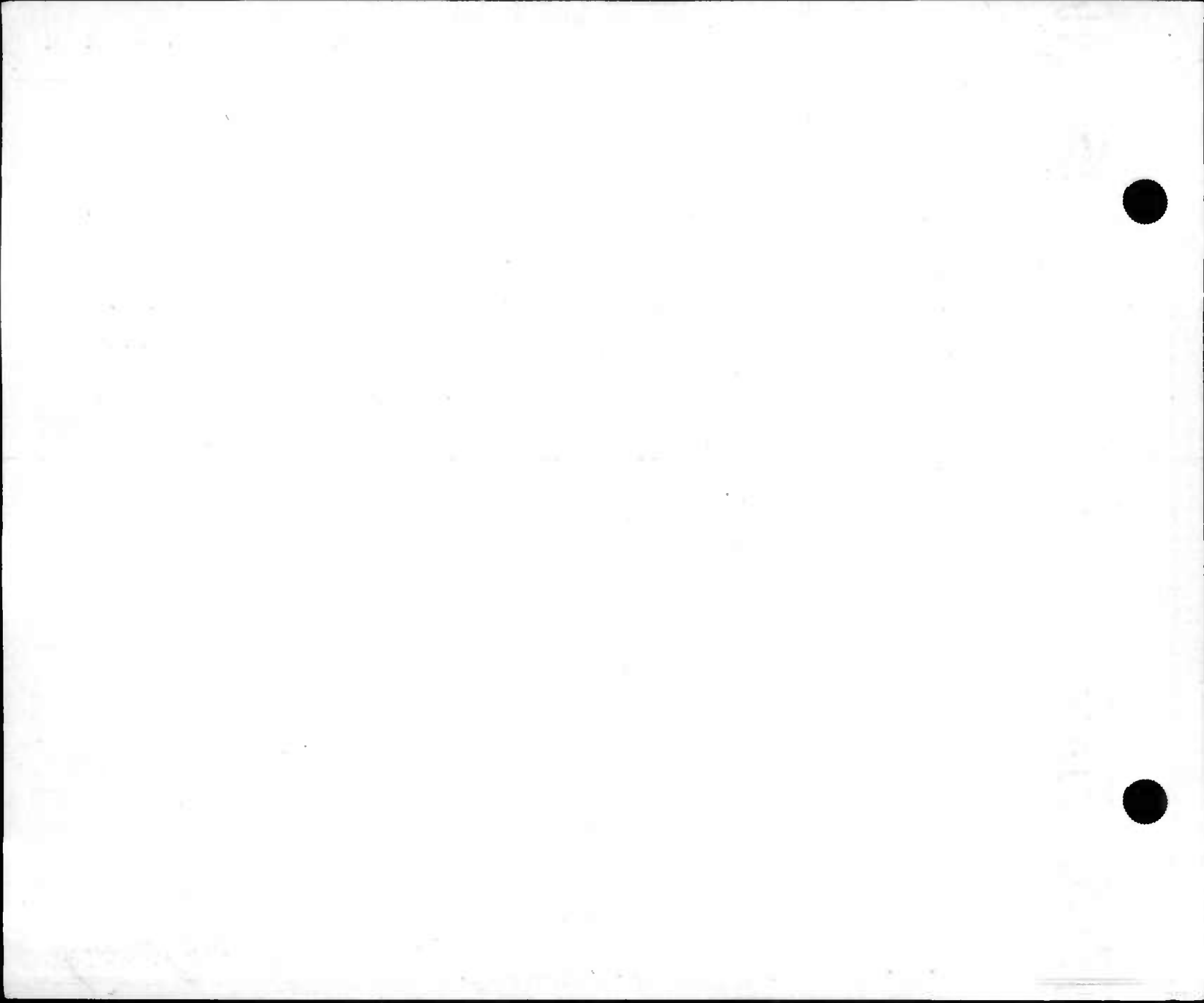
8 0

2 8 2 2 2

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>CARRIE MAE JOHNSON  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 29, 1980         |   | 2b. HOUR<br>M  |
| 3. SEX<br>Female  | 4. RACE<br>Negro   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 26 17   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>63<br>YRS  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VA   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                                       |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3309 Ravenwood Ave. |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |   | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br>MD  |  | 13b. COUNTY   | 13c. CITY OR TOWN<br>Baltimore                                   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>3309 Ravenwood Ave.   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>James Griffin   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Carrie Griffin   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>N/A   |  | 17. INFORMANT<br>ADDRESS<br>Margaret Ford 3309 Ravenwood Rd.                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio respiratory Arrest</u><br>4254<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>Severe Cardiovascular</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) this hospital attended the deceased from April 19 80, to Nov 19 80, that (I) (we) last saw the deceased alive on mid Nov 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |
| 22b. SIGNATURE<br>M. Stracke MD   |  | DEGREE<br>MD  |  | 22c. DATE SIGNED<br>12/2/80   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Mary Stracke   |  | 22e. ADDRESS<br>Balto City Hosp   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   | 23b. DATE<br>12/4/80   | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore Cem   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore MD                                      |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H  |  | ADDRESS<br>1101 E. North Ave.   |  | 25. DATE REC'D. BY REGISTRAR<br>DEC 4 1980  |  |



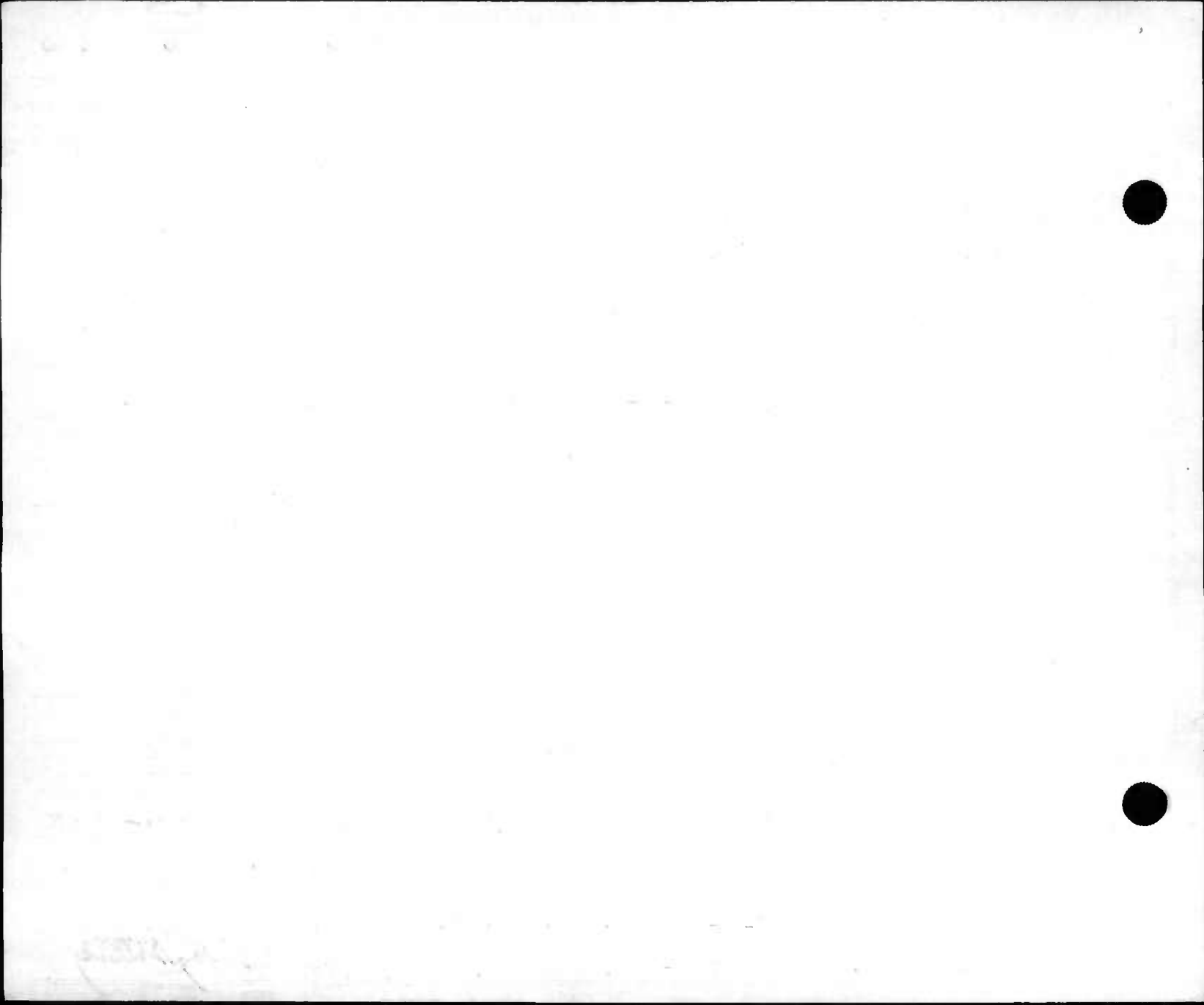
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

2 8 2 2 3

REG. NO.

|   |        |   |  |  |     |   |          |
|---|--------|---|--|--|-----|---|----------|
| 1. FOR<br>STATE<br>REGISTRAR  |        | 2a. DATE OF DEATH   |  | MONTH  | DAY | YEAR  | 2b. HOUR |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |        | FIRST   |  | MIDDLE   |     | LAST  |          |
| CORNELIUS   |        | JOHNSON   |  | 11   |     | 7 80  |          |
| 3 SEX   | 4 RACE | 5 DATE OF BIRTH   |  | 6 AGE (IN YEARS LAST BIRTHDAY)   |     | 7 IF UNDER 1 YEAR   |          |
| MALE  | BLACK  | MONTH DAY YEAR  |  | 67 YRS   |     | IF UNDER 24 HRS   |          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |        | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>   |     | 9 BALTIMORE CITY OR COUNTY OF DEATH                               |          |
| VIRGINIA  |        | US  |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |     | CITY MD.  |          |
| 10 CITY OR TOWN OF DEATH  |        | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR MOST OF WORKING LIFE)  |     | 12b. KIND OF BUSINESS OR INDUSTRY                                 |          |
| BALTIMORE   |        | SINAI HOSPITAL  |  | RETIRED  |     |   |          |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |        | 13b. STATE  |  | 13c. CITY OR TOWN  |     | 13d. INSIDE CITY LIMITS?  |          |
| MARYLAND  |        | BALTIMORE   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |     | 13e. STREET ADDRESS   |          |
| 14 FATHER'S NAME  |        | 15. MOTHER'S MAIDEN NAME  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |     | 16b. SOCIAL SECURITY NO.  |          |
| ANDREW  |        | LILLIAN   |  | YES  |     | 216-05-6721   |          |
| 17 INFORMANT  |        | ADDRESS   |  | 18a. DATE OF OPERATION   |     | 18b. CONDITION FOR WHICH OPERATION WAS PERFORMED                  |          |
| ALICE JOHNSON   |        | 2626 WOODBROOK AVE.   |  |  |     |   |          |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ANOXIC ENCEPHALOPATHY</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>STEVEN-JOHNSON SYNDROME, S/P CARDIAC</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>ARREST - 7 days back</u><br><u>THROMBOCYTOPENIA, CONT. REFRACTORY DIARRHOEA.</u> |        | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  | 20a. AUTOPSY?  |     | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH? |          |
| 6951  |        |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |     | YES <input type="checkbox"/> NO <input type="checkbox"/>          |          |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><u>BLEEDING UGI, &amp; LGI, GENERALIZED ANASARCA.</u>  |        |   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>  |     | 21b. TIME OF INJURY   |          |
|   |        |   |  | OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |     | HOUR A.M. MONTH DAY YEAR  |          |
|   |        |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |     |   |          |
| 21d. INJURY OCCURRED  |        | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION  |     | 21g. COUNTY   |          |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |        |   |  | STREET   |     | STATE   |          |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10-17</u> 19 <u>80</u> , to <u>11-7</u> 19 <u>80</u> , that (I) (we) last<br>saw the deceased alive on <u>11-7</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.             |        | 22b. SIGNATURE  |  | DEGREE   |     | 22c. DATE SIGNED  |          |
|   |        | ANUSHA KHIANEY  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |     | 11-7-80   |          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |        | 22e. ADDRESS  |  | 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |     | 23b. DATE   |          |
| ANUSHA KHIANEY  |        | SINAI HOSPITAL  |  | BURIAL   |     | 11-12-80  |          |
| 24 FUNERAL DIRECTOR   |        | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |     | 26. NAME  |          |
| ELIZABETH L. PHILLIPS   |        | NOV 12 1980   |  | L. Phillips  |     | ADDRESS   |          |
|   |        |   |  |  |     | 1721-27 N. MONROE ST.   |          |



FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 2 2 4

REG. NO.

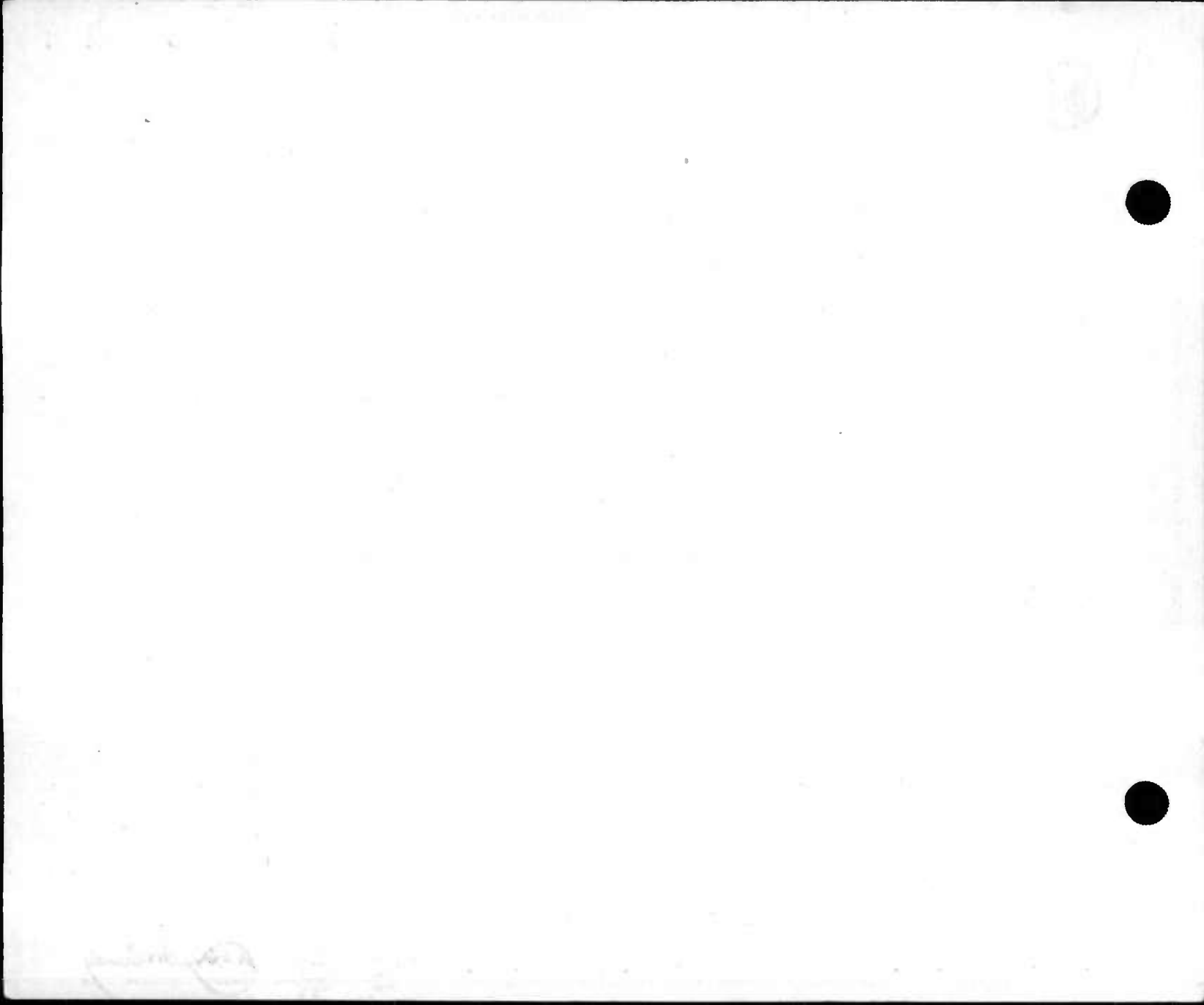
|   |  |   |  |  |                              |   |
|---|--|---|--|--|------------------------------|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Elijah Johnson</i>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>11 25 80</i>                               |  | 2b. HOUR<br><i>2 45 A.M.</i> |   |
| 3. SEX<br><i>M</i>  | 4. RACE<br><i>Black</i>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>8 18 90</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS MONTHS DAYS<br><i>90</i>        |                              | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>MD</i>                              | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.      |                              |   |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore City</i>                                  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>South Baltimore General Hospital</i> |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)       |                              | 12b. KIND OF BUSINESS OR INDUSTRY                               |
| 13a. STATE<br><i>MD</i>   | 13b. COUNTY<br><i>Baltimore</i>  | 13c. CITY OR TOWN<br><i>Baltimore</i>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><i>301 McMechen St Apt 317</i>                  |                              |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Rubin Johnson</i>                      |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Hester Boone</i>  |  |  |                              |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES NO OR "UNKNOWN")<br><i>Yes</i> |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>218-07-9191</i>   |  | 17. INFORMANT<br>ADDRESS<br><i>Roosevelt Grandy 1926 N. Payson St.</i> |                              |   |

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <i>Sepsis</i><br><i>5939</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <i>Large decubitus ulcers</i><br>(c) <i>End Stage Renal Disease</i>                |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (this hospital) attended the deceased from <i>11-22</i> , 19 <i>80</i> , to <i>11-25</i> , 19 <i>80</i> , that (we) lost saw the deceased alive on <i>11-25</i> , 19 <i>80</i> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |
| 22b. SIGNATURE<br><i>Miguel Fleischman</i>   |  |  |  | 22c. DATE SIGNED<br><i>11-25-80</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Miguel Fleischman</i>  |  |  |  | 22e. ADDRESS<br><i>South Baltimore General</i>                                       |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>   |  | 23b. DATE<br><i>12/2/80</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Arbutus Memorial</i>                        |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>Wm. C. March F/H 1101 E. North Ave.</i>   |  | 25a. DATE REC'D. BY REGISTRAR<br><i>NOV 28 1980</i>                    |  | 25b. REGISTRAR'S SIGNATURE<br><i>Ricky Reddy</i>                                     |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Baltimore Co. MD</i>  |  |  |  |  |  |

BP  
DHMM-16 20M  
(VRA 15, 4) 7/78

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed within 72 hours after death. This certificate should be attached to the funeral home's record. Pages 3 and 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 2 2 5

REG. NO.

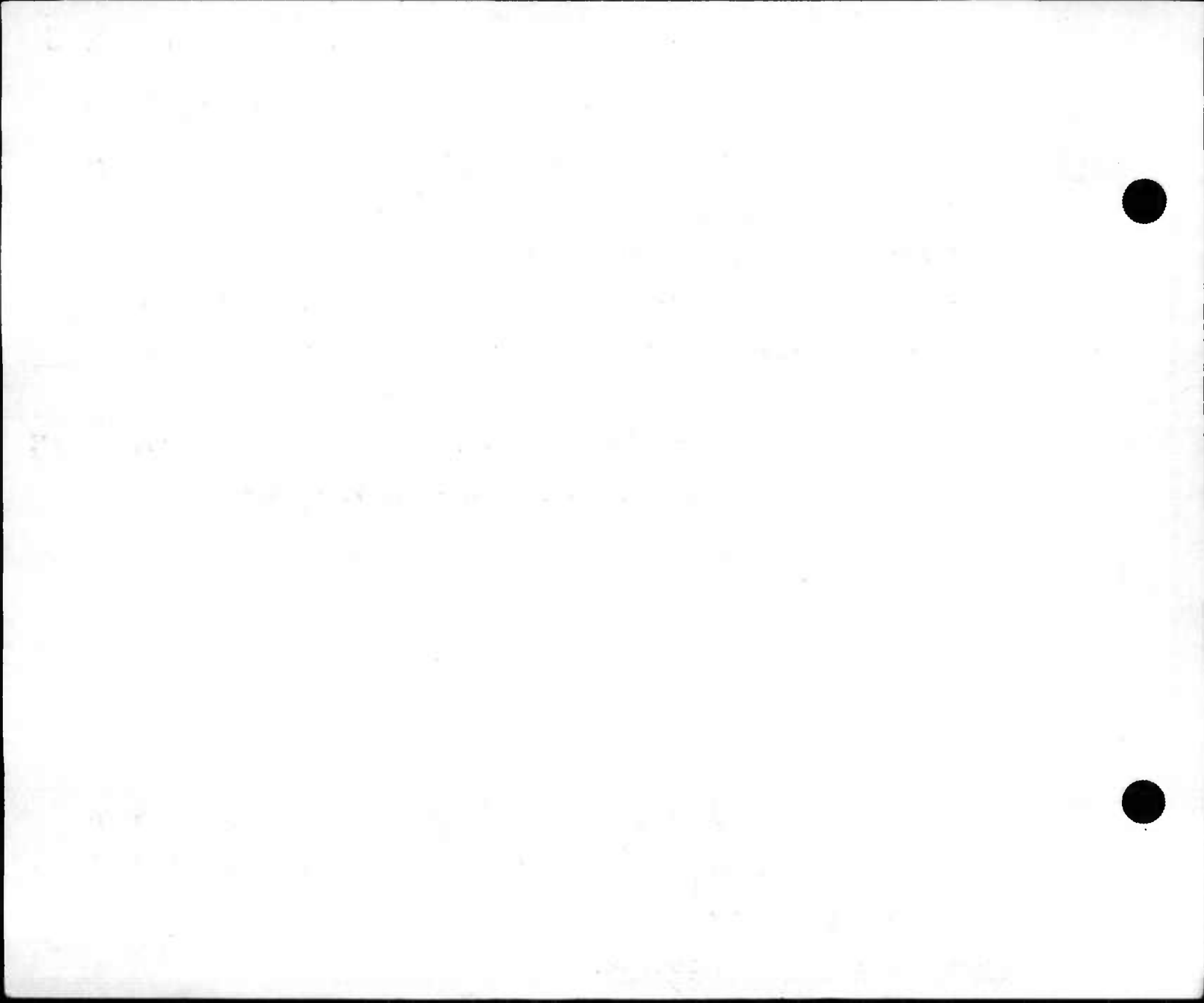
1. FOR  
STATE  
REGISTRAR

|  |  |  |   |  |                                   |
|--|--|--|---|--|-----------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>JOSHUA JOHNSON   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 28 80   |  | 2b. HOUR<br>107 PM                |
| 3. SEX<br>MALE   | 4. RACE<br>BLACK   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>NOV 28 80  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS MONTHS DAYS<br>16 5 |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD. |                                   |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MARYLAND | 13b. COUNTY  | 13c. CITY OR TOWN<br>BALTIMORE   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>333 E. Lorraine Avenue              |                                   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOSHUA EUGENE JOHNSON  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>WANDA ALVIER GAUSE  |   |  |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO                 |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT<br>ADDRESS<br>BIRTH CERTIFICATE              |                                   |

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest</u><br>7650<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>severe prematurity - 26 wks by dates</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>none</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>9 AM - 1 PM                          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |
| 19a. DATE OF OPERATION<br>N/A  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 28</u> , 19 <u>80</u> , to <u>Nov 28</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>Nov 28</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                 |  |  |  |  |  |
| 22b. SIGNATURE<br><u>William A. Pankey</u><br>DEGREE   |  |  |  | 22c. DATE SIGNED<br>11/28/80   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>William A. Pankey, M.D.   |  |  |  | 22e. ADDRESS<br>22 South Green st Balto. Md. 21201                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Removal   |  | 23b. DATE<br>12/4/80   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Anatomy Board  |  | ADDRESS<br>Balto., Md.   |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 9 1980  |  |
|  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Robert McCreedy</u>                                 |  |

BP  
DHHM-16 20M  
(VRA 15, 4) 7/78

TO HOSPITAL, ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4, may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 28226

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |  |                                     |  |   |   |   |                          |  |
|--|--|---|--|--|-------------------------------------|--|---|---|---|--------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Laura May Johnson</i> |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>11 - 4 - 80</i>            |  | 2b. HOUR<br>MIN<br><i>11 45 A M</i> |  |   |   |   |                          |  |
| 3 SEX<br><i>Female</i>   |  | 4 RACE<br><i>Black</i>  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><i>9 15 07</i>  |                                     | 6 AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br><i>73</i>                  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |   |                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                     | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>City</i> MD.              |   |   |   |                          |  |
| 10. CITY OR TOWN OF DEATH<br><i>Balto</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Harford Gardens</i> |  |  |                                     | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)     |   | 12b. KIND OF BUSINESS OR INDUSTRY                               |   |                          |  |
| 13a. STATE<br><i>MD</i>  |  |   | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><i>Balto</i>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><i>Harford Gardens N. 11</i> |                          |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Preston Ramsey</i>                       |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Lolia Killen</i> |  |                                     | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) |   |   |   | 16b. SOCIAL SECURITY NO. |  |
| 17 INFORMANT<br><i>Naomi Robinson</i>  |  |   | ADDRESS<br><i>616 E Horah Street</i>                                 |  |                                     |  |   |   |   |                          |  |

|   |  |  |  |
|---|--|--|--|
| 18 CAUSE OF DEATH Enter only one cause per (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Arteriosclerotic Cardio-Vascular Disease</i><br><i>4292</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>Years</i> |  |
|---|--|--|--|

|  |  |  |  |
|--|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |
| <i>Multiple CVA's</i>  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                  |  |
| 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <i>Dec. 15</i> , 19 <i>74</i> , to <i>Mar. 4</i> , 19 <i>80</i> , that (1) (we) lost saw the deceased alive on <i>Oct. 20</i> , 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did not) view the body after death. |  | 22c. DATE SIGNED<br><i>11/4/80</i>   |  |
| 22b. SIGNATURE<br><i>Loy M. Zimmerman MD</i>   |  | 22d. ADDRESS<br><i>3202 Harford Rd, Baltimore</i>  |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Loy M. Zimmerman MD</i>  |  | 22f. ADDRESS<br><i>3202 Harford Rd, Baltimore</i>  |  |

|  |  |                             |  |  |  |   |  |
|--|--|-----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>                    |  | 23b. DATE<br><i>11/8/80</i> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>MT Auburn</i> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Balto MD</i> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>Donald E. Cluck 1348 N Calhoun St</i> |  |                             |  | 25a. DATE REC'D. BY REGISTRAR<br><i>NOV 6 1980</i>     |  | 25b. REGISTRAR'S SIGNATURE<br><i>Robert M. Brady</i>          |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |  |  | REG. NO. 8 0 2 8 2 2 7 |  |
|--|--|---|--|---|--|--|--|--|--|------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>NORMAN JOHNSON</b>  |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11/1/80</b>  |  | 2b. HOUR<br><b>10:02 PM</b>  |  |                        |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>BLACK</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>APRIL 7, 1910</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70 years</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |  |  |                        |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST AGNES HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>FARMER</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>FARM</b>   |  |                        |  |
| 13a. STATE<br><b>MARYLAND</b>  |  |   |  |   |  | 13b. COUNTY<br><b>PR. GEO. 'S</b>  |  | 13c. CITY OR TOWN<br><b>BOWIE</b>  |  |                        |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JACOB T. JOHNSON</b>  |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>  |  |  |  |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>579 16 3431</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>DAVID M. JOHNSON 6403 KILMER LN. CHEVERLY, MD.</b>   |  |  |  |  |  |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of lung -</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |  |  |  |  |  |                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Congestive heart failure -</b>  |  |   |  |   |  |  |  |  |  |                        |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |                        |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |                        |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/1/80</b> , 19 <b>80</b> , to <b>11/1/80</b> , 19 <b>80</b> , that (I) (we) lost<br>saw the deceased alive on <b>11/1/80</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |  |  |                        |  |
| 22b. SIGNATURE<br><b>Bich Thuy Duong</b> DEGREE<br><b>M.D.</b>   |  |   |  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11/1/80</b>   |  |                        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BICH THUY DUONG, M.D.</b>  |  |   |  |   |  | 22e. ADDRESS<br><b>900 CATON AVE BALTIMORE MD 21229</b>  |  |  |  |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>11/5/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>RESURRECTION</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>CLINTON, MARYLAND</b>   |  |  |  |                        |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>ROLLINS FUNERAL HOME, INC.</b><br>4339 HUNT PLACE, N. E.<br>WASHINGTON, D. C. 20016   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 12 1980</b><br>REGISTRAR'S SIGNATURE<br><i>Anthony McCreedy</i>                                    |  |  |  |                        |  |

BALTIMORE CITY

ST. JOSEPH HOSPITAL

BALTIMORE

RECEIVED BY THE CITY OF BALTIMORE



Items 23a to 23d g550 12/8/80 gj

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

2 8 2 2 8

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |   |  |   |   |  |   |  |
|--|--|---|---|---|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Randolf Johnson</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11-20-80</b>                  |   |  | 2b. HOUR<br><b>9:30 AM</b>  |   |  |   |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br>(Type) <b>Black</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>08-25-14</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS.                               |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>USA S. CAROLINA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.               |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>South Baltimore General Hosp.</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>NONE</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |
| 13a. STATE<br><b>MD</b>  |  |   | 13b. COUNTY   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>501 Dolphin St. Apt. 1411</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Thomas J. Johnson</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Amelia Streeter</b> |   |  |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>UNK.</b>  |  |   | 16b. SOCIAL SECURITY NO.<br><b>245-22-5076</b>                          |   | 17. INFORMANT ADDRESS  |   |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Chronic myelocytic leukemia</b><br><b>2051</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Acute fibrinous pericarditis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |   |   |  |   |   |  |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                        |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>       |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19              |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/16</b> 19 <b>80</b> , to <b>11/20</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>11/20</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |  |   |   |  |   |  |
| 22b. SIGNATURE<br><b>Sandra L. Howard</b>  |  |   |   |   | DEGREE<br><b>MD.</b>   |   |   | 22c. DATE SIGNED<br><b>11/20/80</b>  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Sandra L. Howard</b>   |  |   |   |   | 22e. ADDRESS<br><b>3001 S. HANOVER ST.</b>                                     |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>11/24/80</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Zion Church Cem</b>               |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Cheraw, S.C.</b>                               |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Charles H. Powell F. H. 319 North Schorder St.</b>  |  |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 21 1980</b>                            |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



✓



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 2 2 9

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|   |   |   |  |   |   |  |
|---|---|---|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Sadie H. Johnson</b> |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>Nov. 9, 1980</b>                                  |   | 2b. HOUR<br><b>2:25 PM</b>  |  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>Black</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>April 16, 1905</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS.                 | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                |  |
| 10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                        | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD. |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                       | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2631 Cylburn Ave. 21215</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Machine Oper.</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>G.L. Martin</b>                     |  |
| 13a. STATE<br><b>Maryland</b>   |   |   | 13b. COUNTY<br><b>Baltimore</b>  | 13c. CITY OR TOWN<br><b>Baltimore</b>                             |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Isaac Medford Holly</b>                |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Nellie Demby</b>                     |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |   |   | 16b. SOCIAL SECURITY NO.<br><b>220-14-7094</b>   |   | 17. INFORMANT ADDRESS<br><b>Mrs. Annie J. Smith-2631 Cylburn Ave. 21215</b> |  |

11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4275  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

1 hour

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

## MEDICAL CERTIFICATION

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>September 1, 1977</b> , to <b>November 9, 1980</b> , that (1) (we) last saw the deceased alive on <b>Oct 19, 1980</b> , and that in (m) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (and not) view the body after death. |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Dean Krass MD</b>  |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>11/11/80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dean Krass MD</b>   |  | 22e. ADDRESS<br><b>601 N Broadway Balt Md 21205</b>                    |  |  |  |

|   |                              |  |  |
|---|------------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                  | 23b. DATE<br><b>11/13/80</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Deer Park Mem. Gard</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Finksburg Md. Carroll Co.</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Herbert E. Nutter-3035 W. North Ave.</b> |                              | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 13 1980</b>              | 25b. REGISTRAR'S SIGNATURE<br><i>History McHenry</i>                           |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

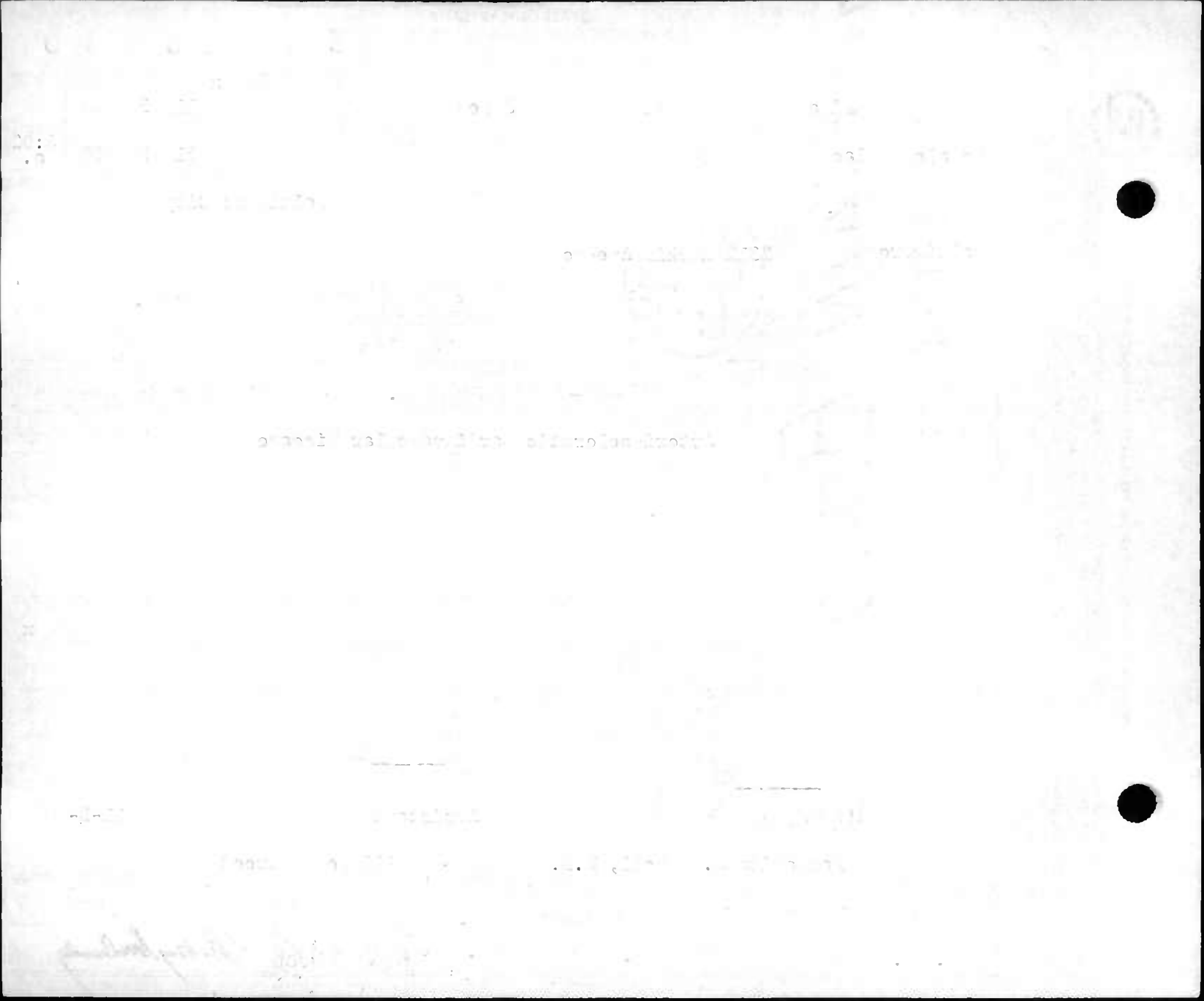


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |  |         |  |   |  |                         |  |   |  |   |  |                                      |  |           |  |  |  |  |  |   |  |                  |  |  |  |  |  |  |  |   |  |
|--|--|---------|--|---|--|-------------------------|--|---|--|---|--|--------------------------------------|--|-----------|--|--|--|--|--|---|--|------------------|--|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |         |  |   |  |                         |  |   |  | 8 0 2 8 2 3 0   |  |                                      |  |           |  |  |  |  |  |   |  |                  |  |  |  |  |  |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |         |  |   |  |                         |  |   |  | 2b. DATE KNOWN OF DEATH ESTIMATED                           |  |                                      |  |           |  |  |  |  |  | 2b. HOUR  |  |                  |  |  |  |  |  |  |  |   |  |
| Alma J. Jones  |  |         |  |   |  |                         |  |   |  | MONTH DAY YEAR<br>11 3 1980                                 |  |                                      |  |           |  |  |  |  |  | M<br>4:02 a.m.  |  |                  |  |  |  |  |  |  |  |   |  |
| 3. SEX   |  | 4. RACE |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS)       |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS.  |  | 7c. DATE PRONOUNCED DEAD             |  | 24 HOUR   |  |  |  |  |  |   |  |                  |  |  |  |  |  |  |  |   |  |
| Female   |  | Black   |  | MONTH DAY YEAR<br>9 5 08  |  | LAST BIRTHDAY<br>72 YRS |  | MONTHS DAYS   |  | HOURS MIN.  |  | MONTH DAY YEAR<br>11 3 1980          |  | 4:02 a.m. |  |  |  |  |  |   |  |                  |  |  |  |  |  |  |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |         |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |                         |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |           |  |  |  |  |  |   |  |                  |  |  |  |  |  |  |  |   |  |
| Ark.   |  |         |  | USA   |  |                         |  |   |  |   |  | Baltimore City MD.                   |  |           |  |  |  |  |  |   |  |                  |  |  |  |  |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH  |  |         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                         |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY    |  |           |  |  |  |  |  |   |  |                  |  |  |  |  |  |  |  |   |  |
| Baltimore  |  |         |  | 2312 Ruskin Avenue  |  |                         |  |   |  |   |  |                                      |  |           |  |  |  |  |  |   |  |                  |  |  |  |  |  |  |  |   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |         |  |   |  |                         |  |   |  | 13d. INSIDE CITY LIMITS?                                    |  |                                      |  |           |  |  |  |  |  | 13e. STREET ADDRESS   |  |                  |  |  |  |  |  |  |  |   |  |
| 13a. STATE MD  |  |         |  |   |  |                         |  |   |  | 13b. COUNTY   |  |                                      |  |           |  |  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |  | 2312 Ruskin Ave. |  |  |  |  |  |  |  |   |  |
| 14. FATHER'S NAME  |  |         |  |   |  |                         |  |   |  | 15. MOTHER'S MAIDEN NAME                                    |  |                                      |  |           |  |  |  |  |  |   |  |                  |  |  |  |  |  |  |  |   |  |
| FIRST MIDDLE LAST<br>Reese Fielder   |  |         |  |   |  |                         |  |   |  | FIRST MIDDLE LAST<br>Mahalia Gene                           |  |                                      |  |           |  |  |  |  |  |   |  |                  |  |  |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |  |         |  |   |  |                         |  |   |  | 16b. SOCIAL SECURITY NO.                                    |  |                                      |  |           |  |  |  |  |  | 17. INFORMANT ADDRESS   |  |                  |  |  |  |  |  |  |  |   |  |
| No   |  |         |  |   |  |                         |  |   |  | 217-22-2333   |  |                                      |  |           |  |  |  |  |  | John R. Jones 2312 Ruskin Avenue  |  |                  |  |  |  |  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |         |  |   |  |                         |  |   |  |   |  |                                      |  |           |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |                  |  |  |  |  |  |  |  |   |  |
| PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease  |  |         |  |   |  |                         |  |   |  |   |  |                                      |  |           |  |  |  |  |  |   |  |                  |  |  |  |  |  |  |  |   |  |
| 4292 } DUE TO, OR AS A CONSEQUENCE OF  |  |         |  |   |  |                         |  |   |  |   |  |                                      |  |           |  |  |  |  |  |   |  |                  |  |  |  |  |  |  |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |  |         |  |   |  |                         |  |   |  |   |  |                                      |  |           |  |  |  |  |  |   |  |                  |  |  |  |  |  |  |  |   |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF   |  |         |  |   |  |                         |  |   |  |   |  |                                      |  |           |  |  |  |  |  |   |  |                  |  |  |  |  |  |  |  |   |  |
| (c)  |  |         |  |   |  |                         |  |   |  |   |  |                                      |  |           |  |  |  |  |  |   |  |                  |  |  |  |  |  |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |         |  |   |  |                         |  |   |  |   |  |                                      |  |           |  |  |  |  |  |   |  |                  |  |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |         |  |   |  |                         |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |                                      |  |           |  |  |  |  |  | 20. AUTOPSY?  |  |                  |  |  |  |  |  |  |  |   |  |
|  |  |         |  |   |  |                         |  |   |  |   |  |                                      |  |           |  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |  |                  |  |  |  |  |  |  |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |         |  |   |  |                         |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19     |  |                                      |  |           |  |  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |                  |  |  |  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |         |  |   |  |                         |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  |                                      |  |           |  |  |  |  |  | 21f. LOCATION CITY OR TOWN COUNTY STATE                                       |  |                  |  |  |  |  |  |  |  |   |  |
|  |  |         |  |   |  |                         |  |   |  |   |  |                                      |  |           |  |  |  |  |  |   |  |                  |  |  |  |  |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |         |  |   |  |                         |  |   |  |   |  |                                      |  |           |  |  |  |  |  |   |  |                  |  |  |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE <i>Margarita A. Korell</i>  |  |         |  |   |  |                         |  |   |  | TITLE (SPECIFY) Assistant                                   |  |                                      |  |           |  |  |  |  |  | DATE SIGNED 11-3-80   |  |                  |  |  |  |  |  |  |  |   |  |
| M.D.   |  |         |  |   |  |                         |  |   |  | MEDICAL EXAMINER  |  |                                      |  |           |  |  |  |  |  |   |  |                  |  |  |  |  |  |  |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.  |  |         |  |   |  |                         |  |   |  | ADDRESS 111 Penn Street                                     |  |                                      |  |           |  |  |  |  |  |   |  |                  |  |  |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial   |  |         |  |   |  |                         |  |   |  | 23b. DATE 11/6/80   |  |                                      |  |           |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY Baltimore Cem.                             |  |                  |  |  |  |  |  |  |  |   |  |
|  |  |         |  |   |  |                         |  |   |  |   |  |                                      |  |           |  |  |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore MD                       |  |                  |  |  |  |  |  |  |  |   |  |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H   |  |         |  |   |  |                         |  |   |  | ADDRESS 1101 E. North Ave.                                  |  |                                      |  |           |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR NOV 5 1980                                      |  |                  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE <i>L. J. [Signature]</i> |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                         |  |   |  |  |  |  |  | REG. NO. 28231  |  |                              |  |
|--|--|-------------------------|--|---|--|--|--|--|--|---|--|------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Brain Andre Jones</b>   |  |                         |  |   |  |  |  |  |  | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>11 21 1980</b> |  | 2b. HOUR<br><b>10:42 P M</b> |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Black</b> |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>12 17 63</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>16</b>  |  | IF UNDER 1 YR. MONTHS DAYS<br><b>0 0</b>   |  | IF UNDER 24 HRS. HOURS MIN.<br><b>0 0</b>   |  |                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, Md.</b>  |  |                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University Hospital</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                              |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                         |  |   |  |  |  |  |  |   |  |                              |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY             |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>749 W. Saratoga St.</b>  |  |   |  |                              |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Edward Jones, Sr.</b>  |  |                         |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Doris Harris</b>                            |  |  |  |   |  |                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br><b>No</b>  |  |                         |  | 16b. SOCIAL SECURITY NO.<br><b>215-76-7662</b>  |  |  |  | 17. INFORMANT ADDRESS<br><b>Doris Jones 749 W. Saratoga Street</b>   |  |   |  |                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>9654</b> IMMEDIATE CAUSE (a) <b>Gunshot Wound of Chest (unspecified)</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF                 |  |                         |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |                              |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a.  |  |                         |  |   |  |  |  |  |  |   |  |                              |  |
| 19a. DATE OF OPERATION   |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |  |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                          |  |                              |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                         |  | 21b. TIME OF INJURY HOUR <del>XXX</del> MONTH DAY YEAR<br><b>9:45 P.M. 11 21 1980</b>   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Subject shot during altercation</b>                                  |  |   |  |                              |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>street</b>  |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br><b>700 Blk. Saratoga St., Baltimore City, Md.</b>  |  |   |  |                              |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                         |  |   |  |  |  |  |  |   |  |                              |  |
| ACTUAL SIGNATURE <b>Virginia L. Dolan</b> M.D.   |  |                         |  |   |  | TITLE (SPECIFY) <b>Assistant</b> MEDICAL EXAMINER DATE SIGNED <b>11/22/80</b>                |  |  |  |   |  |                              |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b> ADDRESS <b>111 Penn Street</b>  |  |                         |  |   |  |  |  |  |  |   |  |                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |                         |  | 23b. DATE<br><b>11/26/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Calarvy St.</b>                                 |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Anne Arundel Co., Md.</b>                                   |  |                              |  |
| 24. FUNERAL DIRECTOR NAME <b>Wm C March F/H</b> ADDRESS <b>1101 E. North Ave.</b>  |  |                         |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 25 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>  |  |   |  |                              |  |

NOV 2 5 1991

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |   |  |   |  |  |  | 8 0 2 8 2 3 2  |  |  |  |
|--|--|--|--|---|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  | CERTIFICATE OF DEATH  |  |   |  | REG. NO.   |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>DONALD F. JONES   |  |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>11 16 80  |  |  |  | 2b. HOUR<br>M  |  |  |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>CAUCASIAN   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>08 30 26   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>54 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN.  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>NORTH CAROLINA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY City MD.                               |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>6515 DANVILLE AVE. |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>MANAGER                        |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>AIR EXPRESS   |  |  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE MARYLAND 13b. COUNTY BALTIMORE 13c. CITY OR TOWN BALTIMORE  |  |  |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>6515 DANVILLE AVE.  |  |  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>DAVID W. JONES  |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>MARY -----  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>YES   |  | 16b. SOCIAL SECURITY NO.<br>WW 11 066189763  |  | 17. INFORMANT ADDRESS<br>MARY BLAKE 509 S. LUZERNE AVE,   |  |   |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c)<br>PART 1: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>4149 Hypertensive Cardiovascular Disease</u><br>DUE TO OR AS A CONSEQUENCE OF<br>(b) <u>Ischemic Cardiovascular Disease</u><br>DUE TO OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |   |  |  |  |  |  |  |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>Insulin Dependent Diabetes Mellitus</u>   |  |  |  |   |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Kenneth L. Glick</u> MD   |  |  |  |   |  | DEGREE<br>MD  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>11-17-80   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Kenneth L. Glick MD   |  |  |  |   |  | 22e. ADDRESS<br>Baltimore City Hospital   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  |  |  | 23b. DATE<br>11/19/80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>GARDENS OF FAITH  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>BALTO. BALTO. MD.   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br><u>John J. Coach</u>  |  |  |  |   |  | ADDRESS<br>1211 Chesaw Ave.   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 24 1980   |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |  |  |  |

BP

DHMH-16 50M 7/77  
(VRA 15 (4))



1 11

100-30

100-30

100-30

100-30

100-30

100-30

100-30

100-30

100-30

100-30

100-30

100-30

100-30

100-30

100-30

100-30

100-30

100-30

100-30

100-30

100-30

100-30

100-30

100-30

100-30

100-30

100-30

100-30

100-30





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 2 3 3

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|  |  |   |  |  |                           |  |
|--|--|---|--|--|---------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Dorothy Jones</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11-18-80</b> |  | 2b. HOUR<br>M<br><b>M</b> |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1-6-1910</b>  |                           | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>70</b>   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |                           | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>city</b> MD   |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2503 Violet Ave. Apt. 809</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |                           | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Balto.</b>   |                           | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles Bobbitt</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Estelle Brown</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |                           | 16b. SOCIAL SECURITY NO.<br><b>215-01-5999</b>   |
| 17. INFORMANT<br><b>Ruth Banks</b>   |  | ADDRESS<br><b>same</b>  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cord embolism</b><br><b>4292</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>After the Cord embolism</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |                           | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |  |                           |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                           | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                           |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                           |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>10/13/80</b> to <b>10/13/80</b> that (2) (we) last saw the deceased alive on <b>10/13/80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (3) (we) (and) (I) did not perform the body after death. |  |   |  |  |                           |  |
| 22b. SIGNATURE<br><b>N.E. McCann MD</b>  |  | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |                           | 22c. DATE SIGNED<br><b>11/20/80</b>  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>N.E. McCann MD</b>   |  | 22e. ADDRESS<br><b>2600 p. body Hte Ave Balto Md 21218</b>  |  |  |                           |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11-22-80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Pk.</b>  |                           | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b>  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Vernon Bailey F.H.</b>  |  | ADDRESS<br><b>1348 Calhoun Street</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 20 1980</b>  |                           | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony K. K...</b>   |

35  
35  
300  
1  
9  
9  
1

MEDICAL CERTIFICATION



1-2-1

*[Handwritten signature]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 8 0 2 8 2 3 4   |  |
|---|--|---|--|---|--|
| 1 - FOR STATE REGISTRAR   |  |   |  | REG. NO.  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FRANK M. JONES  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>11/20/80  |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>WHITE  |  | 2b. HOUR<br>7:20 PM   |  |
| 5. DATE OF BIRTH MONTH DAY YEAR<br>12 29 93   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>86 YRS.  |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.  |  | 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>MERCY HOSPITAL                                 |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>WELDER   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>B & O RR   |  | 13. STREET ADDRESS<br>2612 COLE ST.   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>FRANK CHARLES JONES  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>EMMA SHAW   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO   |  |
| 16b. SOCIAL SECURITY NO.<br>705-07-6382   |  | 17. INFORMANT<br>MARIE JONES  |  | ADDRESS<br>2612 COLE ST.  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u><br>5698<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>S/P bowel perforation</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ |  |   |  |   |  |
| 19a. DATE OF OPERATION<br>10/31/80  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Bowel perforation   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  | 22a. I certify that (I) (this hospital) attended the deceased from 10/22, 1980, to 11/20, 1980, that (I) (we) last saw the deceased alive on 11/20/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE<br>Robert Day Robert Day   |  |
| 22c. DATE SIGNED<br>11/20/80  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. DeMarco Dr. DeMarco  |  | 22e. ADDRESS<br>Mercy Hospital  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  | 23b. DATE<br>11/24/80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>LORRAINE PARK CEMETERY WOODLAWN   |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE<br>BALTO MD.  |  | 24. FUNERAL DIRECTOR NAME<br>HUBBARD FUNERAL HOME 4107 WILKENS AVE.   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 24 1980  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 2 3 5

REG. NO.

|  |                                     |   |  |   |  |
|--|-------------------------------------|---|--|---|--|
| 1. DECEASED NAME<br>(Type in Print)<br>Novella L. Jones  |                                     |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 2 80                 |   | 2b. HOUR<br>1:20 P.M.  |
| 3. SEX<br>Female   | 4. RACE<br>Negro                    | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 20 19   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>61 YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Provident Hospital                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  |
| 13a. STATE<br>MD   |                                     | 13b. COUNTY   | 13c. CITY OR TOWN<br>Baltimore                                 | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>1230 W. Mosher St.  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Alford E. Smith  |                                     | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lillie Wilson  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |                                     | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>N/A  | 17. INFORMANT<br>ADDRESS<br>Karen Wheeler 841 W. Lexington St. |   |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cerebral accident<br>4360<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |                                     |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |                                     |   |  |   |  |
| 19a. DATE OF OPERATION   |                                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                     | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |                                     | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/28, 1980, to 11/2, 1980, that (I) (we) lost saw the deceased alive on 11/2, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                             |                                     |   |  |   |  |
| 22b. SIGNATURE<br>Veita J. Bland M.D.  |                                     | DEGREE  |  | 22c. DATE SIGNED<br>11/2/80   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Veita J. Bland M.D.   |                                     | 22e. ADDRESS  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |                                     | 23b. DATE<br>11/7/80  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cem.          |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Co. MD   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H   |                                     | ADDRESS<br>1101 E. North Ave.   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 5 1980   | 25b. REGISTRAR'S SIGNATURE<br>Lillian M. Brady   |

MEDICAL CERTIFICATION

29

35  
39  
300  
1

1601



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination must be made.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 2 3 6

REG. NO.

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Ozella (Occella) G. JORDAN</b>  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>11 18 80</b>  |  | 2b. HOUR<br><b>1154</b>   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>6 1 98</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN.<br><b>82</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Georgia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sinai Hospital</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b></b>  |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b></b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Clifford N. Smith</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Martha</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>253-16-1932</b>  |  | 17. INFORMANT ADDRESS<br><b>Rev. Arneyb Waters 2621 Cylburn Ave.</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arrhythmia.</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br><b>C Atherosclerotic Cardiovascular Disease</b><br><b>B Renal failure, Dehydration</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Paget's Disease of Bone</b> |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/13</b> , 19 <b>80</b> , to <b>11/18</b> , 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>11/18</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |  |   |  |
| 22b. SIGNATURE <b>Paul Schwartz</b>   |  |   |  | DEGREE <b>M.D.</b>   |  | 22c. DATE SIGNED <b>11/18/80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PAUL Schwartz M.D.</b>   |  |   |  | 22e. ADDRESS <b>Sinai Hosp Belvedere &amp; Greenspring Ave</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11/22/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holly Hill Cem.</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore Co MD</b>   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Wm. C. March F/H</b>  |  |   |  | ADDRESS<br><b>1101 E. North Ave.</b>   |  | 25a. DATE REC'D BY REGISTRAR<br><b>NOV 21 1980</b>  |  |



100-15-100



TO HOSPITAL OR ATTENDING PHYSICIAN: This day requires that the death certificate be completed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80  
(VRA 15, 4)1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

800 28237

|  |  |  |  |   |  |  |   |  |  |
|--|--|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>HUGH WILSON JOSEPHS M.D.</b>   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>NOV. 30, 1980</b>                           |   |  | 2b. HOUR<br><b>9:30 AM</b>   |   |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>JAN 13, 1892</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>88</b>  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NEW ORLEANS, LA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>PHYSICIAN</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>MEDICINE</b>   |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>  |  | 13c. CITY OR TOWN<br><b>RUXTON</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 13e. STREET ADDRESS<br><b>915 ROLAND VUE RD</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>LYMAN COLT JOSEPHS</b>   |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>ALICE WILSON</b>                  |   |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>W.W. I 220-30-3058</b>                              |   |  | 17. INFORMANT ADDRESS<br><b>CHARLOTTE MCCARTHY, MD.</b>  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b><br><b>5850</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ASPIRATION OF SECRETIONS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>CHRONIC RENAL FAILURE</b>   |  |  |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 MIN</b><br><b>2 days</b><br><b>MANY YEARS</b>                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>FRACTURE (R) FEMUR</b>   |  |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION<br><b>—</b>   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>—</b>                       |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CERTIFYING <input checked="" type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY HOUR AM. MONTH DAY YEAR<br><b>7 P.M. NOV 10 1980</b>           |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>OSTEOPOROTIC FRACTURE</b> |  |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>Home</b> |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br><b>915 ROLAND VUE RD. BALTO, BALTO. MD</b>                   |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>NOV 13</b> , 19 <b>80</b> , to <b>NOV 30</b> , 19 <b>80</b> , that (I) (we) lost<br>saw the deceased alive on <b>NOV 30</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Gerald E. Bunker</b>  |  |  | DEGREE<br><b>M.D.</b>  |   |  | CERTIFICATION APPROVED BY MEDICAL EXAMINER<br>PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>30 NOV 80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>GERALD E. BUNKER</b>   |  |  | 22e. ADDRESS<br><b>313 WOODLAWN RD, BALTO 21210</b>                                |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>CREMATION</b>  |  |  | 23b. DATE<br><b>12/2/80</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Balto., Md.</b> |  |  |
| 24. FUNERAL DIRECTOR<br><b>HENRY W. JENKINS</b>  |  |  | ADDRESS<br><b>4905 YORK RD</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 1 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert McElroy</b>           |  |  |

MEDICAL CERTIFICATION



RECEIVED  
JAN 10 1960



*[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed and signed by the attending physician or attending physician retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |   |  |  |   |  |
|--|--|--|--|---|---|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO. 8028238   |  |   |   |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>CHINNAPA JUBBANDA   |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>NOVEMBER 16, 1980 |  |  | 2b. HOUR<br>02:49 AM  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Indian  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>May 8, 1924  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>56 YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>India   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>India  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Cook  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Food                                 |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br>5501 1/2 York Road                                 |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Ayapa Jubbanda  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>UnKnown  |  |   |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>227-80-6646  |  | 17. INFORMANT ADDRESS<br>Mr. Louis Kokkinakos 509 Tunbridge Road  |   |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>RENAL FAILURE</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>AORTIC ANEURYSMS</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>30 MIN<br>2 days<br>2 WKS |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>CEREBRAL INFARCTION, RECURRENT SEIZURES, HYPERTENSION</u>  |  |  |  |   |   |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                    |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |   |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>NOV 6, 1980</u> to <u>NOV 16, 1980</u> , that (I) (we) last saw the deceased alive on <u>NOV 16, 1980</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |   |  |  |   |  |
| 22b. SIGNATURE<br>Steven T. Karina   |  |  |  | DEGREE<br>MD  |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>11-16-80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>STEVEN T. KARINA  |  |  |  | 22e. ADDRESS<br>JHH, 601 N. BROADWAY, BALTIMORE MD  |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation   |  | 23b. DATE<br>11/18/80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Greenmount Crematory  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore Maryland  |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br>Ruck Towson Funeral Home, Inc.  |  |  |  | ADDRESS<br>1050 York Road   |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 19 1980   |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]                                 |  |

MEDICAL CERTIFICATION

29

BP

7



FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

2 8 2 3 9

REG. NO.

|   |  |  |  |  |
|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Josephine</b> MIDDLE <b>Jurglewicz</b> LAST <b>Jurglewicz</b>  |  | 2a. DATE OF DEATH MONTH <b>11</b> DAY <b>2</b> YEAR <b>80</b>  |  | 2b. HOUR <b>M</b>  |
| 3. SEX <b>Female</b>  | 4. RACE <b>Cauc.</b>   | 5. DATE OF BIRTH MONTH <b>8</b> DAY <b>6</b> YEAR <b>1913</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS. MONTHS <b>11</b> DAYS <b>2</b> HOURS <b>00</b> MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.                                     |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>John L. Deaton Med. Center</b> | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE <b>Md.</b>   |  | 13b. COUNTY <b>Baltimore</b>   | 13c. CITY OR TOWN <b>Baltimore</b>                         | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>       |
| 14. FATHER'S NAME FIRST <b>Walter</b> MIDDLE <b>Cieslak</b> LAST <b>Cieslak</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Bertha</b> MIDDLE <b>Ciborowski</b> LAST <b>Ciborowski</b>   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS <b>Patricia Golis 527 N. Belnord Ave.</b>                                    |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Recurrent CVA's</b><br><b>2384</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Polycythemia Vera</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Demented aspect #2</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                             |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                     |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Aug 1</b> 19 <b>80</b> , to <b>Nov 2</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>Nov 2</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |  |  |
| 22b. SIGNATURE <b>Julian W. Reed</b>  |  | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED <b>11/3/80</b>  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JULIAN W. REED</b>   |  | 22e. ADDRESS <b>611 S. CHAS ST. BALTO. MD. 21201</b>   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>11/5/80</b>   | 23c. NAME OF CEMETERY OR CREMATORY <b>Holy Rosary Cem.</b> |  |
| 23d. LOCATION CITY OR TOWN <b>Baltimore</b> COUNTY <b>MD.</b>   |  | 23e. DATE REC'D. BY REGISTRAR <b>NOV 6 1980</b>  |  |  |
| 24. FUNERAL DIRECTOR NAME <b>B. Dabrowski &amp; Son</b> ADDRESS <b>2818 E. Baltimore St.</b>  |  | 25. REGISTRAR'S SIGNATURE <b>Robert M. Kelly</b>   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Josephine

June 1910

1000

1000

1000

1000

1000

1000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |  | 8 0 2 8 2 4 0                                |  |
|---|--|--|--|---|--|---|--|--|--|--|--|
| 1- FOR STATE REGISTRAR EGNATIUS KALANDROS   |  |  |  |   |  |   |  |  |  | REG. NO.                                     |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <u>Egnatius</u> ( Jack ) <u>Kalandros</u>   |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH <u>11</u> / DAY <u>12</u> / YEAR <u>80</u>                           |  | 2b. HOUR<br><u>10:35 PM</u>  |  |  |  |
| 3. SEX<br><u>Male</u>   |  | 4. RACE<br><u>White</u>  |  | 5. DATE OF BIRTH<br>MONTH <u>July</u> DAY <u>24</u> YEAR <u>1911</u>  |  | 6. AGE - (IN YEARS LAST BIRTHDAY)<br><u>69</u> YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS <u></u> DAYS <u></u> HOURS <u></u> MIN. <u></u>   |  |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><u>Greece</u>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Baltimore City</u> MD.                               |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><u>Baltimore</u>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>John M Deaton Medical Center</u> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>Chef</u>                 |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>Retired</u>  |  |  |  |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |   |  |   |  |  |  |  |  |
| 13a. STATE<br><u>Maryland</u>   |  | 13b. COUNTY<br><u>Baltimore</u>  |  | 13c. CITY OR TOWN<br><u>Baltimore</u>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><u>1617 N. Spring St</u>  |  |  |  |
| 14. FATHER'S NAME<br>FIRST <u>William</u> MIDDLE <u></u> LAST <u>Kalandros</u>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <u>Athena</u> MIDDLE <u></u> LAST <u>Unknown</u>  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><u>No</u>   |  | 16b. SOCIAL SECURITY NO.<br><u>214-05-0752</u>   |  | 17. INFORMANT<br><u>Mrs Cecilia Greason</u>   |  | ADDRESS <u>220 Birchard Hill Dr</u>   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Arrest 20</u><br><u>4960</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>severe chronic obstructive</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. {<br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Disease of Peptic Ulcer</u> |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <u>19</u>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><u>[Signature]</u> DEGREE   |  |  |  |   |  |   |  |  |  | 22c. DATE SIGNED<br><u>11/16/80</u>          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Desawn Hickey</u>   |  |  |  |   |  | 22e. ADDRESS<br><u>205 B4A Blvd Glen Burnie Md</u>  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>Cremation</u>  |  | 23b. DATE<br><u>11/17/80</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Greenmount</u>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Baltimore, Maryland</u>                        |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <u>Leonard J Ruck Inc. Baltimore, Maryland</u> ADDRESS   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><u>NOV 18 1980</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |  |  |  |

U. S. A. 1911

U. S. A. 1911

U. S. A. 1911

U. S. A. 1911

U. S. A. 1911

U. S. A. 1911







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHM-16 30M 2/80  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |  |  | 80 28241         |  |
|---|--|--|--|--|--|---|--|--|--|------------------|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO.   |  |  |  |   |  |  |  |                  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST  |  | MIDDLE   |  | LAST  |  | 2a. DATE OF DEATH  |  | MONTH DAY YEAR   |  |
| ESTHER  |  | KASEL  |  |  |  |   |  | 11 25 80   |  | 415A M           |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS. |  |
| FEMALE  |  | CAUC   |  | MONTH DAY YEAR<br>1 29 98  |  | 82 YRS.   |  | MONTHS DAYS  |  | HOURS MIN.       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |                  |  |
| RUSSIA  |  | USA  |  |  |  | BALTIMORE CITY  |  |  |  | MD               |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                                     |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |                  |  |
| BALTIMORE   |  | SINAI HOSPITAL   |  | HOUSEWIFE  |  | AT HOME   |  |  |  |                  |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS  |  |                  |  |
| MARYLAND  |  | BALTIMORE  |  | BALTIMORE  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | APT. 612<br>2500 W. BELVEDERE AVE.                             |  | #21215           |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT  |  |                  |  |
| FIRST MIDDLE LAST<br>SAMUEL EISEN   |  | FIRST MIDDLE LAST<br>TOBY ISAACS   |  | NO   |  | 219-32-0062A  |  | MRS. BEVERLY SEVENTHAL   |  |                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  | 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20. AUTOPSY?  |  | 20a. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |                  |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC WITH subsequent respiratory</u><br><u>4439</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>INFARCT MI WITH complete HEART BLOCK</u><br>Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.<br>(c) <u>Severe Peripheral Vascular disease</u> |  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |  |  |   |  |  |  |                  |  |
| <u>Pre-renal azotemia, open foot ulcers with impending gangrene</u>   |  |  |  |  |  |   |  |  |  |                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)   |  |   |  |  |  |                  |  |
|   |  | HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  |  |   |  |  |  |                  |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION  |  |   |  |  |  |                  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  | STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |                  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>Nov 8 1980</u> to <u>Nov 25 1980</u> , that (1) (we) lost saw the deceased alive on <u>Nov 25 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) view the body after death.                         |  |  |  |  |  |   |  |  |  |                  |  |
| 22b. SIGNATURE  |  | DEGREE   |  | 22c. DATE SIGNED   |  |   |  |  |  |                  |  |
| <u>Philip J. Schwartz MD</u>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 11/25/80   |  |   |  |  |  |                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |  |  |   |  |  |  |                  |  |
| PHILIP J. SCHWARTZ MD   |  | SINAI HOSPITAL, BALTIMORE, MD 21215  |  |  |  |   |  |  |  |                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  |  |  |                  |  |
| BURIAL  |  | 11/26/80   |  | FORBAND  |  | CITY OR TOWN COUNTY STATE<br>ROSEDALE BALTO. MD                     |  |  |  |                  |  |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |  |  |                  |  |
| NAME SOL LEVINSON & BROS., INC.<br>6010 REISTERSTOWN RD. BALTO., MD 21215   |  | DEC 3 1980   |  | <u>Robert McCreedy</u>   |  |   |  |  |  |                  |  |

MEDICAL CERTIFICATION

29

2717 BP

April 28 1968

1968

1968



28

1968

1968

1968

1968

1968

1968

1968

1968

1968

1968

1968

1968

1968

1968

1968

1968

1968

1968

1968

1968

1968

1968

1968

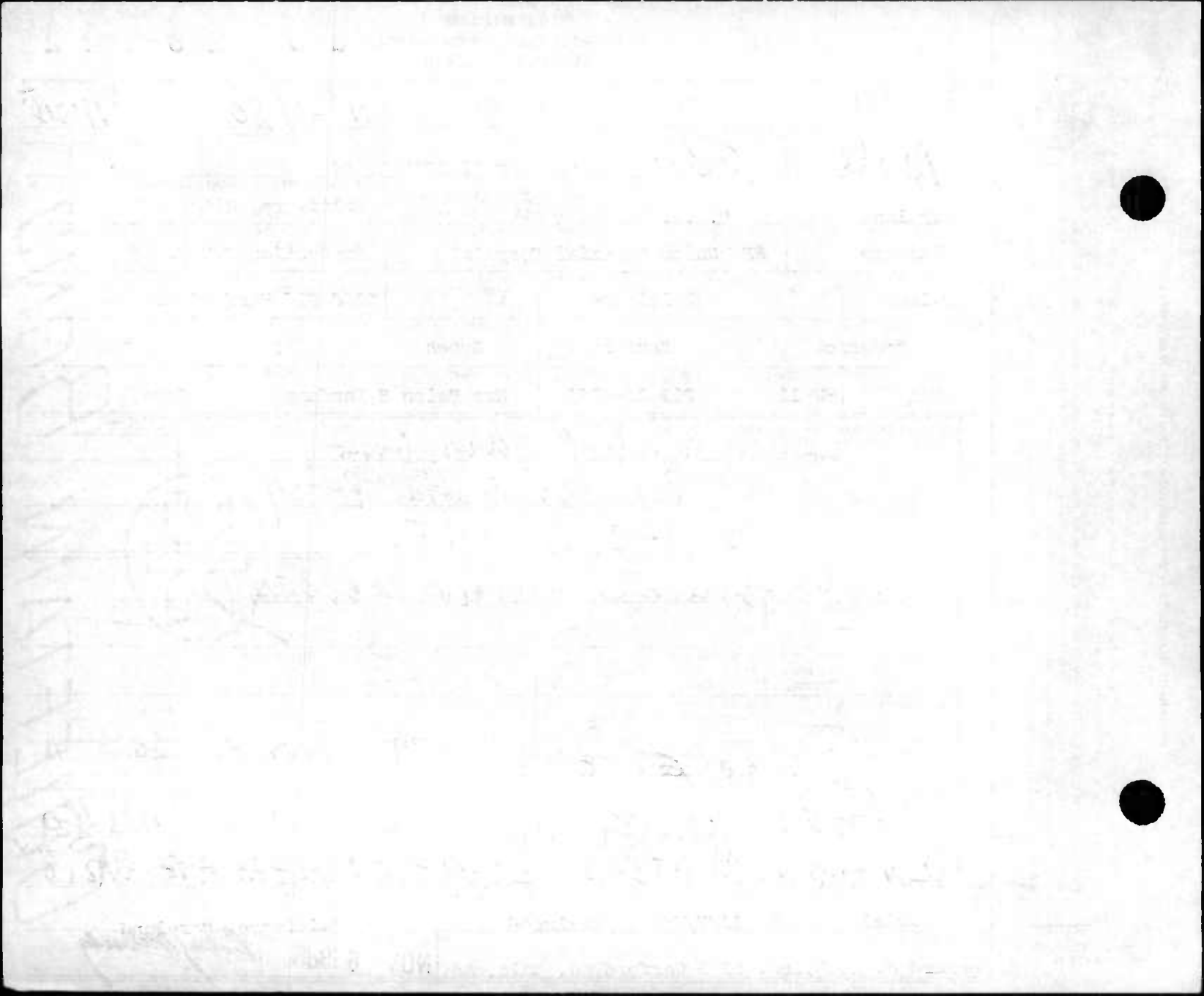
1968

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 2 4 2

REG. NO.

|   |  |   |  |   |  |   |  |  |  |  |  |
|---|--|---|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Neil</b>   |  | FIRST <b>C.</b>   |  | MIDDLE <b>Kaufman</b>   |  | LAST  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11/4/80</b>                                |  | 2b. HOUR<br><b>11:00<sup>AM</sup></b>  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>December 11, 1895</b>  |  | 6. AGE (IN YEARS, LAST BIRTHDAY)<br><b>84</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTH PLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore, City</b> MD.                              |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Union Memorial Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Production G.M.C.</b>    |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   |  |   |  |  |  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>6208 Old Harford Rd</b>                                    |  |  |  |
| 14. FATHER'S NAME<br>FIRST <b>Frederick</b> MIDDLE <b>Kaufman</b> LAST <b>Kaufman</b>   |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Agnes</b> MIDDLE <b>?</b> LAST <b>?</b>                    |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>WW 11 213-10-4751</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs Helen E Kaufman Same</b>                                     |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b><br><b>3352</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arterio-sclerotic changes</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>2 ASCVD C.H.F.</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>State Premature + Social Deprivation</b>   |  |   |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 19c. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>10 P.M. 19</b>  |  | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |  |  |  |  |
| 21a. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   |  | 21b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, ETC.)  |  | 21c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22. I certify that (1) (this hospital) attended the deceased from <b>July 1 1979</b> to <b>Nov 4 1980</b> that (1) (we) last saw the deceased alive on <b>Oct 6 1980</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (I) (do) not see the body after death.                                       |  |   |  |   |  |   |  |  |  |  |  |
| 22a. SIGNATURE<br><b>Donald W. Minter</b>   |  |   |  | DEGREE<br><b>M.D.</b>   |  |   |  | 22b. DATE SIGNED<br><b>11/5/80</b>   |  | 22c. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Donald W. Minter</b>   |  |
| 22d. ADDRESS<br><b>3009 EVERGREEN AVE BALTO</b>   |  |   |  | 22e. ADDRESS<br><b>3009 EVERGREEN AVE BALTO</b>   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |   |  | 23b. DATE<br><b>11/7/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>              |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J. Ruck, Inc.</b>  |  |   |  |   |  | ADDRESS<br><b>5305 Harford Rd. Balt. Md.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 6 1980</b>                                   |  | 25b. SIGNATURE<br><b>[Signature]</b>   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

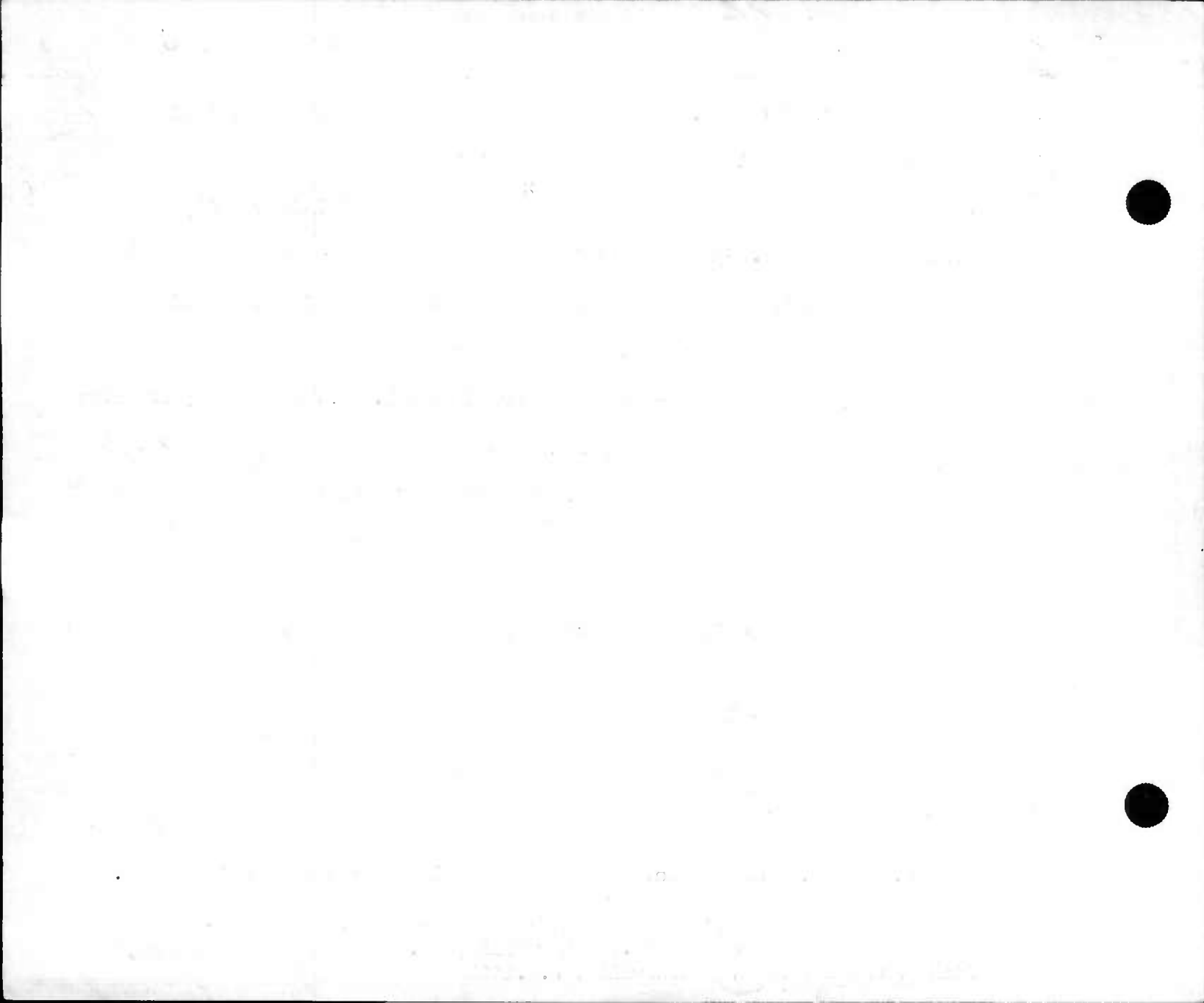
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 0 2 8 2 4 3<br>REG. NO.   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>ELIZABETH M. KEEFER   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>NOVEMBER 30, 1980   |  |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>March 3, 1916  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>64 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U S A   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Agnes Hospital |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Maryland   |  | 13b. CITY OR TOWN<br>Balto  |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13d. STREET ADDRESS<br>602 Meyers Drive  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Henry Roesler   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Margaret Speigel  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO  |  |  |  |
| 16b. SOCIAL SECURITY NO<br>216-24-1548   |  | 17. INFORMANT ADDRESS<br>Christopher L. Keefer, 602 Meyers Drive  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u><br>4140<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <u>Due to, or as a consequence of</u><br>(c) <u>Due to, or as a consequence of</u><br>Approximate interval between onset and death<br><u>18 months</u><br><u>5-6 yrs</u> |  |   |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                         |  |  |  |
| 19a. DATE OF OPERATION<br>5-22-80  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Vent. Aneurysm Resected   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7-13</u> , 19 <u>75</u> , to <u>11-30</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>4-21</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Kyle Y. Swisher Jr MD</u>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br>12-1-80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Kyle Y. Swisher, Jr.  |  |   |  | 22e. ADDRESS<br>3350 Wilkens Ave. Pine Heights Ave.   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>12/4/80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowridge Cemetery  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Dorsey, A.A. Maryland   |  |
| 24. FUNERAL DIRECTOR NAME<br>1630 Edmondson Ave., Catonsville, Md.<br>Witzke Funeral Home of Catonsville, P.A.21228  |  |   |  | 25. DATE REC'D BY REGISTRAR<br>DEC 2 1980   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Robert K. Cuddy</u>   |  |

BP

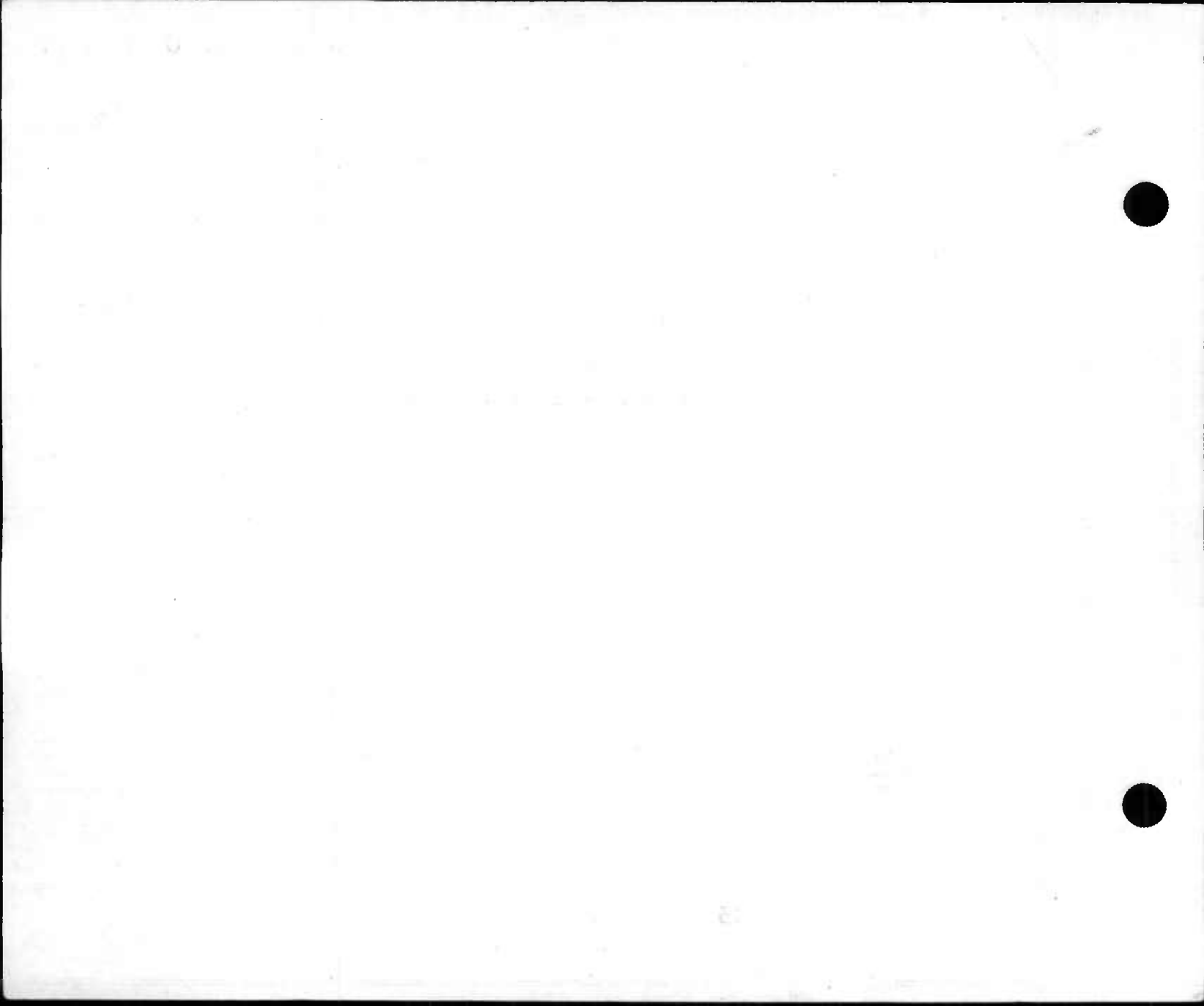


**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

8 0 2 8 2 4 4

REG. NO.

|   |  |   |  |   |  |  |  |  |  |
|---|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Ernest</b>   |  | FIRST MIDDLE LAST <b>Keene</b>  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>November 9 1980</b>                                      |  | 2b. HOUR <b>10:40 A.M.</b>                                       |  |
| 3 SEX <b>M</b>  |  | 4 RACE <b>2</b>   |  | 5 DATE OF BIRTH MONTH DAY YEAR <b>6 15 13</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore Maryland City</b> MD.                       |  |  |  |
| 10 CITY OR TOWN OF DEATH <b>Balto.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Bon Secours Hosp.</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>?</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13a. STATE <b>MD.</b>   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN <b>Balto</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>1800 Edmondson Ave</b>                    |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Carlton Keene</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Beatrice Johnson</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |  | 16b. SOCIAL SECURITY NO. <b>219-05-0743A</b>   |  | 17 INFORMANT ADDRESS <b>Beatrice Keene 1800 Edmondson Avenue</b> |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4280 Congestive Heart Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   |  |   |  |  |  |  |  |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  |   |  |  |  |  |  |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |   |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  |   |  |  |  |  |  |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>   |  |   |  |   |  |  |  |  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   |  |   |  |  |  |  |  |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |   |  |   |  |  |  |  |  |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE <b>Winston Hugh Williams MD</b> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> 22c. DATE SIGNED <b>11/9/80</b>  |  |   |  |   |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Winston Hugh Williams MD</b> 22e. ADDRESS <b>c/o Bon Secours Hospital Dept of Medicine</b>   |  |   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b> 23b. DATE <b>11/13/80</b> 23c. NAME OF CEMETERY OR CREMATORY <b>King Memorial</b> 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>   |  |   |  |   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME <b>William C. March Funeral Home INC.</b> ADDRESS <b>1101 E. North Ave</b> 25a. DATE REC'D. BY REGISTRAR <b>NOV 10 1980</b> 25b. REGISTRAR'S SIGNATURE <b>L. J. Kelly</b>   |  |   |  |   |  |  |  |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8.0 28245  
KEITH, MARY  
003080 REG. NO. 516-20  
2. DATE OF DEATH, MONTH, DAY, YEAR 11-5-80  
2b. HOUR 8:45 P.M.

|  |   |   |   |   |
|--|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MARY MIDDLE KEITH LAST        |   | 2. DATE OF DEATH, MONTH, DAY, YEAR<br>11-5-80   |   | 2b. HOUR<br>8:45 P.M.                   |
| 3. SEX<br>FEMALE   | 4. RACE<br>NEGRO  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2 15 14   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>66 YRS   | 7. UNDER 1 YEAR<br>MONTHS DAYS<br>11 11 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>RICHMOND VA                   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |   |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>NO. CHARLES CON HOSE | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>KORFANDAY   | 12b. KIND OF BUSINESS OR INDUSTRY<br>NATOL  |   |
| 13a. STATE<br>MD   | 13b. COUNTY<br>BALTIMORE  | 13c. CITY OR TOWN<br>BALTIMORE  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>614 N. MOUNT ST  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOE HANCOCK                      |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>VICTORIA BROWN   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>210-22-4045  | 17. INFORMANT<br>ADDRESS<br>KORFANDAY 614 N. MOUNT ST   |   |   |

|  |  |  |
|--|--|--|
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c):<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>pulmonary arrest</u><br>4292<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <u>cardiomyopathy</u><br>(c) <u>ASCVD</u> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

|  |  |  |  |
|--|--|--|--|
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9-30</u> , 19 <u>80</u> , to <u>11-5</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>11-5</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE<br><u>David Strobel</u>   | DEGREE<br>MD   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED<br>11-5-80  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DAVID STROBEL MD  |  | 22e. ADDRESS   |  |

|   |                      |  |  |
|---|----------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  | 23b. DATE<br>11/6/80 | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MD |
| 24. FUNERAL DIRECTOR<br>NAME<br>Mansour A. Bughra (366) |                      | 25. DATE REC'D BY REGISTRAR<br>NOV 7 1980        | 25b. REGISTRAR'S SIGNATURE<br><u>Anthony A. Brady</u>      |

*[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the page. The text appears to be organized into several paragraphs and possibly a list or table structure.]*

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 28246

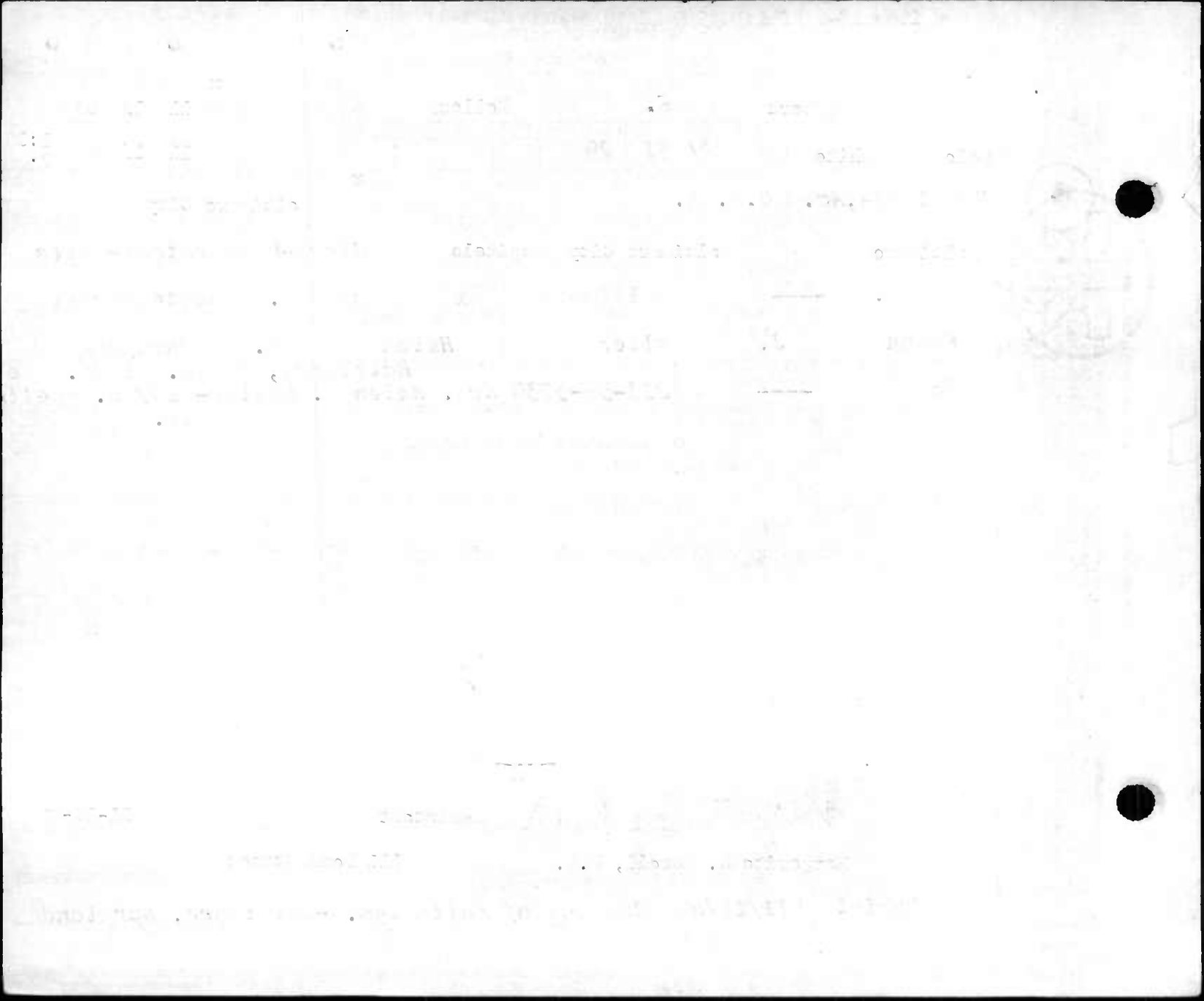
|  |  |  |  |   |  |  |  |  |  |                  |  |                                      |  |       |  |          |  |      |  |           |  |
|--|--|--|--|---|--|--|--|--|--|------------------|--|--------------------------------------|--|-------|--|----------|--|------|--|-----------|--|
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST  |  | MIDDLE  |  | LAST   |  | 2a. DATE KNOWN OF DEATH                      |  | MONTH            |  | DAY                                  |  | YEAR  |  | 2b. HOUR |  |      |  |           |  |
| Robert   |  | E.   |  | Keller  |  |  |  | 11   |  | 15               |  | 19                                   |  | 80    |  | M        |  |      |  |           |  |
| 1. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS)  |  | IF UNDER 1 YR.                               |  | IF UNDER 24 HRS. |  | 7c. DATE PRONOUNCED DEAD             |  | MONTH |  | DAY      |  | YEAR |  | 2d. HOUR  |  |
| Male   |  | White  |  | 6/02/51   |  | 29   |  |  |  |                  |  | 11                                   |  | 15    |  | 19       |  | 80   |  | 1:30 P.M. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED  |  | NEVER MARRIED  |  | WIDOWED                                      |  | DIVORCED         |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |       |  |          |  |      |  |           |  |
| Baltimore, Md.   |  | U.S. A.  |  |   |  |  |  |  |  |                  |  | Baltimore City                       |  |       |  |          |  |      |  |           |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                            |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |                  |  |                                      |  |       |  |          |  |      |  |           |  |
| Baltimore  |  | Baltimore City Hospitals   |  | Clerk-LiquorStore-Sales   |  |  |  |  |  |                  |  |                                      |  |       |  |          |  |      |  |           |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET ADDRESS                          |  |                  |  |                                      |  |       |  |          |  |      |  |           |  |
| Md.  |  | V-----   |  | Baltimore   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 3107 E. Fayette Street                       |  |                  |  |                                      |  |       |  |          |  |      |  |           |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  |   |  |  |  |  |  |                  |  |                                      |  |       |  |          |  |      |  |           |  |
| Frank  |  | Helen  |  |   |  |  |  |  |  |                  |  |                                      |  |       |  |          |  |      |  |           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS  |  |  |  |                  |  |                                      |  |       |  |          |  |      |  |           |  |
| No   |  | 213-52-3730  |  | Mrs. Helen O. Keller  |  | 3107 E. Fayette St.  |  |  |  |                  |  |                                      |  |       |  |          |  |      |  |           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  | PART I DEATH WAS CAUSED BY:  |  | IMMEDIATE CAUSE (a)   |  | DUE TO, OR AS A CONSEQUENCE OF   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                  |  |                                      |  |       |  |          |  |      |  |           |  |
| 95Q3   |  | Mesoridezine intoxication  |  |   |  |  |  |  |  |                  |  |                                      |  |       |  |          |  |      |  |           |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.                                      |  | (b)  |  | DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |                  |  |                                      |  |       |  |          |  |      |  |           |  |
|  |  |  |  | (c)   |  |  |  |  |  |                  |  |                                      |  |       |  |          |  |      |  |           |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |  |  |   |  |  |  |  |  |                  |  |                                      |  |       |  |          |  |      |  |           |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 20. AUTOPSY?  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |                  |  |                                      |  |       |  |          |  |      |  |           |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH     |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |  |  |  |  |                  |  |                                      |  |       |  |          |  |      |  |           |  |
| 11/13/80   |  | Self ingested  |  |   |  |  |  |  |  |                  |  |                                      |  |       |  |          |  |      |  |           |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK                          |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION   |  | CITY OR TOWN   |  | COUNTY                                       |  | STATE            |  |                                      |  |       |  |          |  |      |  |           |  |
| home   |  | 3107 E. Fayette St.  |  | Balto   |  | Md.  |  |  |  |                  |  |                                      |  |       |  |          |  |      |  |           |  |
| 22a. I certify that I took charge of the remains described above, held an  |  | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  | death resulted from:  |  | Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |  |  |                  |  |                                      |  |       |  |          |  |      |  |           |  |
| ACTUAL SIGNATURE   |  | TITLE (SPECIFY)  |  | MEDICAL EXAMINER  |  | DATE SIGNED  |  |  |  |                  |  |                                      |  |       |  |          |  |      |  |           |  |
| Margarita A. Korell  |  | Assistant  |  |   |  | 11-16-80   |  |  |  |                  |  |                                      |  |       |  |          |  |      |  |           |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |  | ADDRESS  |  |   |  |  |  |  |  |                  |  |                                      |  |       |  |          |  |      |  |           |  |
| Margarita A. Korell, M.D.  |  | 111 Penn Street  |  |   |  |  |  |  |  |                  |  |                                      |  |       |  |          |  |      |  |           |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION  |  | CITY OR TOWN                                 |  | COUNTY           |  | STATE                                |  |       |  |          |  |      |  |           |  |
| Burial   |  | 11/18/80   |  | Gardens of Faith Cem.   |  | -Baltimore, Maryland   |  |  |  |                  |  |                                      |  |       |  |          |  |      |  |           |  |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |  |  |                  |  |                                      |  |       |  |          |  |      |  |           |  |
| John A. Moran, Inc.  |  | NOV 19 1980  |  |   |  |  |  |  |  |                  |  |                                      |  |       |  |          |  |      |  |           |  |
| 3000 E. Baltimore St.  |  |  |  |   |  |  |  |  |  |                  |  |                                      |  |       |  |          |  |      |  |           |  |
| Baltimore, Md. 21224   |  |  |  |   |  |  |  |  |  |                  |  |                                      |  |       |  |          |  |      |  |           |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING TO THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN DIVISION 17 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
15M 2/80

0601



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

2 8 2 4 7

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |   |   |  |  |  |
|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>HAROLD MELVIN KELLUM</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 18 80</b>                                 |  | 2b. HOUR<br><b>2:15 P</b>  |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>WHITE</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>09 14 14</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br><b>66</b>                                   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VIRGINIA</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                      |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST AGNES HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>MAINTENANCE</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>CITY OF</b>                            |  |
| 13a. STATE<br><b>MARYLAND</b>  |   |   | 13b. COUNTY<br><b>---</b>  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>RICHARD M. KELLUM</b>   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>EUNICE LEE HUDSON</b>              |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>YES WW II</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>217-18-1249</b>  | 17. INFORMANT<br>ADDRESS<br><b>ANN ELIZABETH TAYLOR 3555 BENZINGER ROAD</b>            |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Anterior Myocardial Infarction</b><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 days</b>  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |   |  |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |   |   |  |  |  |
| 22b. SIGNATURE<br><b>J. Cole, M.D.</b>   |   | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>11/18/80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>J. Cole, M.D.</b>  |   | 22e. ADDRESS<br><b>3455 Wilkens Ave 21229</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  | 23b. DATE<br><b>11-21-80</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LOUDON PARK</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE CITY MARYLAND</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>HUBBARD FUNERAL HOME, INC.</b>  |   | ADDRESS<br><b>4107 WILKENS AVE.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 21 1980</b>                            |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



2551 BP



1940

WASHINGTON

OFFICE



Handwritten signature or initials.

1940



FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

2 8 2 4 8

REG. NO.

|  |   |   |  |  |                      |
|--|---|---|--|--|----------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>JOHN Eschol KELLY   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>NOVEMBER 12, 1980                             |  | 2b. HOUR<br>08:14 PM |
| 3. SEX<br>Male   | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Feb. 28, 1925   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>55 YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |                      |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Powellville, Md.  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                           |  |                      |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Equip. Operator  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Paving  |                      |
| 13a. STATE<br>Maryland   | 13b. COUNTY<br>Wicomico   | 13c. CITY OR TOWN<br>Fruitland  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>106 Spruce Street   |                      |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Howard Edward Kelly  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Sara Helen Davis   |  |  |                      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  | 16b. SOCIAL SECURITY NO.<br>WW II   | 17. INFORMANT<br>ADDRESS<br>Mrs. Nancy D. Kelly (wife) same as 13   |  |  |                      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>acute myelogenous leukemia</u><br>2050<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 wk |   |   |  |  |                      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |   |  |  |                      |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                      |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |                      |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>AT HOME <input type="checkbox"/>   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |                      |
| 22a. I certify that (this hospital) attended the deceased from <u>11/12/80</u> 19 <u>80</u> to <u>11/12</u> 19 <u>80</u> , that (we) last saw the deceased alive on <u>11/12</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |   |   |  |  |                      |
| 22b. SIGNATURE<br><u>DALE RENCUNO</u>  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br>11/12/80   |                      |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DALE RENCUNO  |   | 22e. ADDRESS<br>601 N. Broadway, Baltimore  |  |  |                      |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  | 23b. DATE<br>11/15/80   | 23c. NAME OF CEMETERY OR CREMATORY<br>Wicomico Memorial Park  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Salisbury, Wicomico, Maryland          |  |                      |
| 24. FUNERAL DIRECTOR<br>HOLLOWAY FUNERAL HOME, Salisbury, Maryland   |   | 25. DATE REC'D. BY REGISTRAR<br>NOV 17 1980   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Theresa Kelly</u>   |                      |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 of 4.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in the funeral director's office, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Page 2 should be filed with the funeral director. Page 3 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



EP. 10. 10. 10.

COPIES 1. 1. 1.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |   |   |                            |   |
|--|--|---|---|---|----------------------------|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Bernard C Kennedy</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 22, 1980</b> |   | 2b. HOUR<br><b>12:48AM</b> |   |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec 23, 1904</b>   |                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b><br>YRS. MONTHS DAYS HOURS MIN.                     |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Operator Nat'l Brewery</b>   |                            | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Jeames E Kennedy</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Crilley</b>  |   |   |                            |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>216-01-2805</b>  |   | 17. INFORMANT ADDRESS<br><b>Mrs Eileen Oliver 5537 Bucknell Rd 21206</b>  |                            |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b><br><br>4439 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Status Post Above the Knee Amputation right Foot</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)  |  |   |   |   |                            |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Diabetes Mellitus</b>  |  |   |   |   |                            |   |
| 19a. DATE OF OPERATION<br><b>11/17/80</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Status Post Peripheral vascular disease Transmetatarsal Amputation</b>                 |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                            |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>XXXXXXXXXXXXXXXXXXXXXXXXXXXX</b><br>P.M. 19   |   | 21c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>of the right foot</b>   |                            |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                            |   |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>October 8</b> , 19 <b>80</b> , to <b>November 22</b> , 19 <b>80</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>November 22</b> , 19 <b>80</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death. |  |   |   |   |                            |   |
| 22b. SIGNATURE<br><b>Anthony Tan</b>   |  | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>11/22/80</b>   |                            |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Anthony Tan, M.D.</b>  |  | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>  |   |   |                            |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11/25/80</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood</b>   |                            |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J Ruck Inc. Baltimore, Maryland</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 24 1980</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>P. J. H. H. H.</b>   |                            |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>   |  |   |   |   |                            |   |

